HEALTH CARE REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND TECHNOLOGY

OF THE

COMMITTEE ON SMALL BUSINESS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

PORTLAND, OR, SEPTEMBER 1, 1993

Printed for the use of the Committee on Small Business

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HEALTH CARE REFORM

WEDNESDAY, SEPTEMBER 1, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES, AND TECHNOLOGY,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., at Portland Metro Council Chambers, 600 Northeast Grand, Portland, OR, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman WYDEN. The Subcommittee on Regulation, Business Opportunities, and Technology will come to order, and we want to welcome all our guests, particularly Congressman Kopetski.

Congressman Kopetski serves on the House Ways and Means Committee, which is a committee of enormous importance to our State.

It has been a full decade since we have had someone on that important committee, and we are very pleased that Congressman Kopetski is here today as well, because the Ways and Means Committee, along with the other committee that I sit on, the Energy and Commerce Committee, will be the committees that will be handling the bulk of the health care reform legislation.

Congressman Kopetski and I are convening today's hearing because developing workable solutions to the health care crisis for small business is key to enacting effective health care reform in this Congress.

We believe that this issue is a top economic development concern for Oregon, because our State has one of the largest concentrations of small businesses in the country.

According to the Department of State Economic Development, about half of our State's businesses employ under 50 people, and small business is the muscle and sinew of almost every main street in Oregon.

For thousands of those small Oregon businesses, health costs are their fastest rising expense, and about 185,000 of Oregon's 479,000 uninsured citizens are small business employees or their dependents.

Now, President Clinton has not yet announced his health reform proposal, but press reports that the President's plan will contain mandates that are costly, inflexible, and burdensome have been frightening to many Oregon business owners.

Let me assure Oregon businesses right now: So-called health reform that cripples small business is going to mean Oregonians have fewer jobs and reduced prospects for health coverage, and I

will oppose them, but health reform that produces real cost containment, which in my view is the number one issue for small business, and protects small business employees from unfairly being denied coverage by insurers and preserves choice of providers is going to make Oregon more productive, and I will pull out all the stops to see it enacted.

Now, responsible health reform is going to require that the major economic forces in our society, such as insurance companies, medical providers, trial lawyers, and yes, business, will have to share responsibility and accept changes in the status quo.

Insurance companies are not going to be allowed to cherry-pick any longer and just take healthy people.

Medical providers will face changes in reimbursement practices, particularly for procedures that were once difficult but are now more routine.

Trial lawyers will be required to accept changes that can reduce medical malpractice costs and the expense of defensive medicine.

We are especially interested in hearing today what small business owners and Oregon businesses think they ought to be asked to do as part of the health reform effort.

I am convinced that, working together, this issue can be appropriately dealt with.

Already, there is strong bipartisan support in the Congress and significant support among businesses for many key features of health reform legislation for small business.

For example, there is great support for cost containment through the establishment of purchasing cooperatives that would give small business the same kind of bargaining muscle that the big firms have.

There is great interest in establishing a basic benefit package that focuses on health care prevention.

There is significant support for expanding the tax deduction for the self-employed, Medicaid reform, special consideration for the needs of the smallest businesses, and phasing in the plan over a number of years.

Congressman Kopetski and I are going to be asking about these and other ideas today.

What is clear, however, is the cost of doing health care as usual is prohibitively high. Medical bills are gobbling up everything in sight and, like acid, are eating away at the survivability and profitability of small businesses across Oregon.

Health care reform is finally at the top of the congressional agenda, and Congressman Kopetski and I are here to get the views of Oregon's small businesses for one reason, and that is to do this job right.

So, I am especially pleased to welcome Mike Kopetski today. We are going to be teaming up and working very closely on this issue throughout the Congress, through our committee assignments and our friendship, and I appreciate him coming and want to recognize him for any statement.

[Chairman Wyden's statement may be found in the appendix.]

Mr. KOPETSKI. Thank you, Mr. Chairman, and I think Oregonians know that Ron Wyden, in large part because of his work and knowledge on health care issues, put him in the Congress.

We are very fortunate as a State and as a region to have someone with Congressman Wyden's knowledge and expertise and commitment to this issue to serve in the House of Representatives and, importantly, to be serving on the subcommittee of the Energy and Commerce Committee which has jurisdiction over health care and health care reform matters.

I should just note also that, in the budget reconciliation bill, included in that is a provision that reinstates the 25-percent tax credit for health care coverage for sole proprietorships, of which there are many in Oregon who make up a lot of the small businesses in our State.

I am pleased to be invited to participate in today's hearing on small business and health care reform. Clearly, it is one of the thorniest aspects of health care reform. Small businesses are a crucial part of our economy, and their health is vital to a strong economic recovery.

As we all know, our current health care system is employment-based and has been so since shortly after World War II.

Approximately two-thirds of those with health care insurance under the age of 65 have insurance through an employment-based group, either because their own employer offered it or because they were insured as a result of their being a dependent of a worker whose employer offers group coverage.

It's clear that any health care reform undertaken, whether in the direction of mandating employer coverage or contributions or in the direction of establishing a Government-run single-payer health care system will affect both the businesses that are paying for coverage now and those that are not.

The President is expected to unveil his health care reform proposal by the end of this month, and reports are that the proposal will mandate that employers contribute to the cost of covering their workers.

Indications are that employers will be required to contribute a portion of the market premium for their employees' health plan, but the contribution will be capped at a relatively low percentage for small firms and at a higher percentage for larger firms.

Under the President's proposal, the requirement will be phased in, and assistance will be given to businesses will very low-wage workers and for very small businesses.

Oregon is a particularly apt place to hold this hearing. Oregon has both a higher-than-average percentage of its population without health care insurance and a higher-than-average concentration of small businesses.

Oregon is a small business State. Small firms with 50 or fewer employees represent 96 percent of Oregon businesses and employ 47 percent of its private-sector work force.

Fifty-five percent of Oregon businesses employ between one and four workers, and Oregon has a higher-than-average percentage of agricultural workers, one of the sectors of the economy with a low rate of worker health care.

We must be very careful in working on health care reform to ensure the health of small businesses and family farms in Oregon while improving access to quality health care.

We cannot just enact mandates without addressing the reasons why many small businesses are not providing coverage. Small businesses are at a severe disadvantage in providing health care compared to the large employers.

Small businesses are not able to spread risks widely, are in a weaker bargaining position with the insurance companies than larger employers are, and are faced with much higher administrative costs.

Administrative costs consume 40 percent of every dollar paid in total health premium for businesses with fewer than five employees, compared to administrative costs of around 5 percent per dollar for the larger companies.

We must also keep in mind that small businesses, like all businesses, want to take care of their employees. Despite the steep costs involved, according to the Department of Labor, roughly 62 percent of American businesses with fewer than 100 employees do provide health care coverage to their employees. However, unless we act soon, this percentage will drop significantly.

A recent survey found that 30 percent of small businesses are considering dropping health insurance benefits because of the cost, and 13 percent of respondents to the same questionnaire indicated that they had dropped coverage within the preceding 3 years.

Health care reform, including employer mandates, will simply not work unless we get a handle on the reasons that our current employer-based system is not working now.

I am looking forward to today's hearing and to the release of the President's proposal. Health care reform is going to be successful only if everybody gets into the act.

We must have a full and open debate on the issues involved, and I am pleased to join my colleague, Congressman Wyden, in starting this dialog here in Oregon.

[Mr. Kopetski's statement may be found in the appendix.]

Chairman WYDEN. I thank my friend for his kind comments and excellent statement, and this is going to be a long push, and it is going to be great to pursue it with you, and I think we have a chance to really kick it off today with a great group of witnesses.

Our first panel is going to be Chad Cheriel, who is with the Oregon Office of Health Policy, who over the years has been the source in our State for good, accurate data about Oregonians as it relates to health.

Chad, why don't you come forward? We do swear our witnesses. So, we have got a little bit of protocol here to follow, and I think we are going to get you the microphone here.

Dr. Cheriel, do you have any objection to being sworn as a witness this morning?

Dr. CHERIEL. None at all.

Chairman WYDEN. Please raise your right hand.

[Witness sworn.]

Chairman WYDEN. Well, we welcome you and, again, appreciate all the work that you have done over these many years.

We are going to make your prepared statement a part of the hearing record, and if you could take 5 minutes or so and highlight some of the principle concerns here, particularly to the extent that you can give us new information about the profile you have of

small business in our State and what their costs are and who is uninsured and why, those kinds of issues are particularly helpful to us.

TESTIMONY OF CHAD CHERIEL, DIRECTOR, OREGON OFFICE OF HEALTH POLICY

Dr. CHERIEL. Thank you very much. My name is Chad Cheriel, director for the Office of Health Policy.

I want to thank the Honorable Chair of the committee, Congressman Wyden, and Congressman Kopetski for offering me the opportunity to present some findings and analysis developed by the Office of Health Policy.

Just recently, we issued a report titled "Health Insurance Coverage in Oregon: Estimates for 1990 to 1992." The report was produced with the support of the Robert Wood Johnson Foundation, which has funded a number of States as part of their State health reform initiatives.

In spite of the billions of dollars we spend on health care in this country, only a limited amount of information as to demographics, benefits offered, coverage patterns of population for the insured and uninsured population is available to the public.

The data we have compiled represent the best information available to date about Oregon. These estimates will be refined with additional also supported by the Robert Wood Johnson Foundation and undertaken by the Rand Corp.

They are currently surveying 2,000 businesses and 2,000 households to get a better understanding of the coverage patterns, cost, attitude, and so forth, relating to health insurance.

Before going into the key statistics and findings from the report that we issued, I would like to kind of walk you through a number of slides, overheads, on some of the main concerns that businesses, consumers, and Government have relating to health coverage, if I could walk over to the projector here.

Some of this information is obviously common knowledge these days, the challenge facing the health care system, correcting what is wrong with the present system, and today's focus, in a sense, is primarily on the so-called 15 percent of the population that lacks health insurance. In the State of Oregon, it is closer to 16 percent and growing at an alarming rate. Nationally, as you all know, the numbers range between 35 to 37 million people.

The compelling reason for tackling this issue primarily can be seen this way. There is a significant difference between the rate of growth in health expenditures and what people are able to earn and the rate of growth in the other sector.

It is the gap between the rate of inflation in health care cost, adjusted for inflation, obviously, and the overall price indices and the earning capacity of the population that is driving both the businesses, consumers, and Government and purchasers, in a sense, crazy and searching for solutions.

Clearly, everyone involved in health care reform statistics are aware of the concerns of the business, and since 1965, as you can see, health care cost as a percent of the profit has skyrocketed.

Right now, health care costs far exceed the profit margins of the corporations in this country. So, every dollar you could save essentially translates into a dollar profit for the business community.

Just a minor detail on that one. When you look at health benefits—these are, again, national statistics—in 1971, employee benefits distribution, if you could focus on the health insurance part, that constituted 11.7 percent in '71. Jump to 1990, that same percentage increased to 19.5 percent. That rate of growth has become intolerable.

There is a general sense, often, that businesses are the primary source of funds for health insurance and health coverage, health expenditure in this country, but in fact, if you look at the aggregate statistics, what is seen is that private businesses bear about 30 percent of the total expenditure, public—Medicare, Medicaid, school districts, city, county, State employment—accounts for 34 percent, and households, through direct purchase of insurance, through co-pays, deductibles, purchase of prescription drugs and so forth, bears the brunt of the cost.

This is critical because, often, one of the strategies that people try to talk about is cost shifting or imposing a greater share of the burden on consumers, and this is usually justified on a couple of bases: One, that if you could only make consumers more responsible that somehow you could help drive the cost down, but of all the nations that offer health insurance to their population, the American public bears the largest cost sharing of any industrialized nation, simply to emphasize the point that cost sharing and cost shifting is not the solution that society ought to be looking for.

Now, just a brief highlight of what we have been able to find, looking at the available Oregon statistics, the number one insurer in Oregon is growing each year at about 5 percent, or around 25,000 people per year, and unless something is done, that is going to create major problems for society, the economy, and the welfare of the population.

Oregon looks slightly worse than the Nation as a whole in terms of the percent of the population uninsured. Health insurance is eroding fastest for middle-income families who earn between $15,000 and $45,000 per year.

I believe there are significant implications in that finding, and it makes sense because of the increasing unemployment in the largest sectors of the economy, namely small businesses, in agriculture, and forestry is contributing significantly to this problem.

Seventy-two percent of the uninsured adults work and 69 percent of the uninsured adults are above the Federal poverty line.

Women aged 40 to 49 and men aged 50 to 64 lost coverage between 1990 and '92. This may be the population that used to think of themselves as having secure jobs and full coverage through the work place, and they are, for the first time, because of the changing economy and cost in changing business benefits issues driving by health care costs, are realizing that they are on the chopping block and that they are losing coverage.

Children are doing better, primarily due to increased Medicaid Programs, and most uninsured are over age 30.

That also is a significant finding in that there is a general notion that the uninsured population are the young people who believe

that they are healthy and indestructible and therefore they choose not to purchase health insurance, but the findings are contrary to that.

Just to go quickly to sources of health insurance, Oregon statistics are very similar to the Nation as a whole. Most of the coverage, health insurance coverage, is provided through the employment sector. The national picture is fairly identical, 60 percent as opposed to 61 percent.

Workers with employment-based health insurance, there is significant and clear correlation between the size of the firm and the probability of getting coverage.

As the congressmen already indicated, Oregon is a small business State, and that may partially explain the changes and the higher percentage of the uninsured in the State.

If you work in a firm that employs four or fewer employees, your chances of getting coverage through the employment in Oregon is very small, less than 20 percent.

Chairman WYDEN. Excuse me just a second. This chart is not in the report that you handed out, is it?

Dr. CHERIEL. That is right. It is something that we have developed since then.

Chairman WYDEN. You have developed this since then. We would like a copy of that for the record, and this is especially helpful, because I think that, as we try to get to the next tier in this debate, with all the interest in small business issues, this is especially helpful.

Dr. CHERIEL. We will supply that to you.

As the size of the firm goes up, obviously the businesses are in a position to offer coverage to the workers.

Just a corollary statistic relating to the national scene: In the Nation as a whole, there is a better probability of coverage than for those one-to-four-employee firms, and actually, across the board, Oregon lags behind.

Uninsured working adults and dependents by size of the employer in 1992, this has some implications for the State initiatives that are underway.

The most recent Oregon legislature amended the existing legislation to offer mandated coverage for employees, and what this tells you is that, as of March 1997, if laws do not change, assuming no changes in law, employees working in firms with 26 or greater number of employees will be picked up through the Oregon health plan and the employer mandate, and in 1998, an additional 185,000 Oregonians will become eligible for health insurance coverage under the State initiatives.

This chart is somewhat similar to the national statistics. In the country as a whole, 49 percent of the uninsured population are in small businesses of firm size 25 or fewer employees; in Oregon, that figure is 59 percent, as opposed to the 49 percent.

So, that confirms what has already been stated, that Oregon has a larger number of its work force working in firms with fewer employees.

These are employment by types of industry. If you happen to work in manufacturing, transportation, wholesale trade, Govern-

ment, or education, the likelihood of getting coverage is very high, 80 percent or better.

If you happen to work in industries of agriculture, forestry, construction, retail trade, and business services, the likelihood of getting coverage through employment is reduced significantly; some, obviously, as you can see, as low as the uninsured population or the insured population together ranging below 40 percent.

This, again, restates what has been stated before. Most of the uninsured do work. In Oregon, 45 percent or so of the uninsured workers work full-time, another 27 percent work part-time, and an additional 28 percent of the population is not in the labor force, and this, again, is more or less consistent with some of the national statistics, although in the Nation as a whole, about 55 percent of the uninsured work full-time.

A couple of other demographics about Oregon—I will quickly walk through these.

This, again, reemphasizes the rate of change in terms of the people losing their insurance coverage is most noticeable in the income group that ranges from $15,000 to $45,000.

The total numbers are not as significant as the ones in the $5,000 to $15,000, but the rate of change in loss of coverage is significant for that middle income category.

Uninsured and the poverty level—again this somewhat relates back to the Oregon health plan.

As part of the Oregon health plan, the population below 100 percent of poverty, about 147,000 people, will become eligible, potentially, for expanded Medicaid coverage, and Oregon will be searching for policies that will enable the State to bring the rest of the population—that is, the 144,000 plus the 188,000—into some sort of health coverage system.

This is, again, family composition of the uninsured in 1992.

There are, obviously, a significant portion of that as single with no children, about 209,000 of them. There are single parents with children constituting another 68 percent. Married population under 62,000 and married with children another 140,000 Oregonians.

Chairman WYDEN. Chad, we probably ought to move on, so we can get to some questions.

Dr. CHERIEL. I am about done.

The last thing is just only a promise. We are working to see the uninsured by race, and this is national statistics, and we are trying to sort out what the State profile looks like.

What is shows in the Nation is that the burden of uninsurance is more heavily borne by the black and Hispanic population.

That is pretty much the slides I have, and I will simply summarize by saying this clearly calls for effective action on the part of State and national leaders, and as the Chairman indicated, cost containment must and has to be part of whatever form we are going to undertake, simply because there are those of us who believe that there may be plenty money in the system; we need the courage to figure out how best to use it to bring in all those millions of people who are currently without direct access to health care.

Thank you very much.

[Dr. Cheriel's statement may be found in the appendix.]

Chairman WYDEN. Well said, as always, and we appreciate it, and let me begin the questioning with Congressman Kopetski.

Mr. KOPETSKI. Thank you, Mr. Chairman.

Doctor, thank you very much for that brief but to-the-point overview of the picture here.

How effective and advisable do you think barebones packages are in making health insurance more affordable for small businesses?

Dr. CHERIEL. Congressman Kopetski, that is a tough one, because as long as you have barebones policies, I think we will continue to maintain a system that will allow providers to cost-shift, meaning that will not to lead to any sort of ultimate solution that we need to have.

There are plenty of resources in the system in terms of personnel, in terms of technology, in terms of facilities. I think the challenge for the political leaders is to design a system so that everybody will have access to the needed and appropriate levels of care.

Mr. KOPETSKI. Your statistics show that the smaller the business the more uninsured, the larger the business the converse, and one of the things that you do not show is the fact that a corporation gets to deduct the cost of their health insurance, whereas a small business, if they are not a corporation—and we have a lot of those that are sole proprietorships or partnerships—they do not get this tax benefit. We reinstituted the 25-percent credit for them, but it is not 100-percent.

What kind of—or how great of a subsidy do you think it will take in terms of this tax-credit approach so that we would get similar numbers to our large corporations as we have—that we do not have now?

Dr. CHERIEL. Congressman Kopetski, if you would allow us another year or so, those are some of the questions that we are currently studying as part of the Oregon health plan, looking at the level of subsidy needed to enable small firms to satisfactorily provide coverage for the population, and you are addressing an issue much more complex than that in terms of tax subsidy both at the State and Federal level, and I think Oregon will be one of the lead States in the country in terms of addressing that issue, and I think we will have better answers down the line.

Mr. KOPETSKI. The final question I have for you—do you care to comment on a single-payer system? Would you support that? Why or why not?

Dr. CHERIEL. I am willing to come at it this way.

As far as I am concerned, it does not matter what sort of system we have, whether it is a single-payer, all-payer, employment-based, individual mandate, as long as we could come up with a system that will guarantee access to everyone with a rate of growth that society can tolerate that is commensurate with the rate of increase in income, rate of growth in the economy. I think that will satisfy most of the population.

A single-payer system, once the details are worked out and once it could be shown that we could effectively maintain that system, it will be wonderful, but I think my understanding of the American political process convinces me that any system that relies on the public sector may not be the best solution for the American public,

because in my experience anyway, the public always gets picked on by others.

Therefore, there are some built-in problems with a single-payer system that is tied to a great public involvement. It will be open to all kinds of criticism.

Even though many other countries have been very effective in delivering wonderful health care for its citizenry through such a system, whether or not it will work in the United States is still open to question.

Mr. KOPETSKI. When a politician says they have a last question, that means they really have one more.

It is my understanding that the age of populations has a lot to do with the cost of health care in this society. Do you do an analysis or have you done an analysis of the age of Oregon's population versus—do we fit the national norm?

Do we have more elderly in this State? Are we going to have more elderly in this State? Obviously, that is where a lot of the cost is, in the last 4 months or so of a person's life.

Dr. CHERIEL. Three quick answers.

The Nation as a whole, the United States as a whole, in relation to most of the developed nations, the percentage of the seniors in this country is less than other countries, and the importance of that is other nations have found ways to provide good care to the citizens by spending fewer resources than we have.

Second, I have heard statistics thrown out that Oregon may have a higher percentage of its population as seniors. It depends on who you compare that to. Clearly, in parts of the State, there are greater populations of seniors who are moving into the coastal communities. We will have some of those statistics down the line, and we are looking at it.

Third, I was going to say was clearly there is a correlation between age and expenditure. All insurance companies take that into account.

National studies have shown that Medicare expenditure clearly is testimony to the fact that a higher-age population consumes extraordinary portions of the health resources.

Mr. KOPETSKI. OK. Thank you. Thank you, Doctor.

Chairman WYDEN. I thank my colleague.

Dr. Cheriel, there are constantly thrown around estimates of how many businesses offer a health benefit package to their people, and I know you are pursuing this now, but what would be your guess as to the percentage of businesses in Oregon that offer a health benefit package to their workers?

Dr. CHERIEL. Congressman Wyden, unfortunately I do not have that number.

Part of the difficulty is, in terms of counting the number of small firms in the State, we are in the process of working with the employment division and the corporate division and trying to identify the total number of small businesses in the State. So, it creates some difficulties in terms of coming up with that calculation.

What we do know are the statistics we have shown. Among the small businesses, there is less coverage, and the higher the number of employees with the firm, the greater the coverage.

Chairman WYDEN. Do you think about 50 percent is a ballpark?

What Congressman Kopetski and I are constantly told in DC is that about two-thirds of the businesses offer coverage to their people, but my sense, as I listen to businesses in Oregon, particularly given the huge number of small businesses we have, my guess is it may be less than two-thirds in our State and that it may be closer to half. Any even kind of rough estimate in this ballpark?

Dr. CHERIEL. Well, I think you are guessing it right, and on my part, it will also be a guess. Given the large number of small firms in the State, my guess would be that Oregon is unlike other States in that 50 percent of the firms may not offer health insurance coverage.

Chairman WYDEN. We will await your data, and obviously, that is something that is really key for Mike and I to get, because all of this stuff is talked about in the abstract and national averages, and we are going to be thinking about the small mill in Mike's district and the shop keeper in Gresham in my district.

What could you tell us—and maybe this is a little bit easier—in terms of what the profile of a small business' health package might be? Do we have any idea what kinds of benefits the typical small business offers? Can you give us something of a profile in terms of what they would offer their people?

Dr. CHERIEL. Our understanding, preliminary understanding, is that those who offer benefits tend to offer a fairly decent set of components of the health insurance package.

However, having said that, Oregon, through one of its initiatives, the so-called insurance pool governing board, they attempt, through a tax incentive, to voluntarily entice small businesses into offering health insurance.

There is a package that is priced at $53 per person per month. That is a barebones package, but the administrator of that program has testified at various occasions that business are not necessarily buying that, even though that is available. They are opting for a much richer set of benefits.

So, my guess would be that those who are offering coverage, they are offering a fairly decent package, rather than a barebones package.

Chairman WYDEN. Any sense in terms of the split in terms of financing, if it is 50-percent employer, 50-percent employee? What can you tell us that you have been picking up in terms of the split between employer and employee?

Dr. CHERIEL. I would answer that by saying what we ought to be maybe looking at is separating health insurance coverage from the employment base—I know that is a real tough problem, but some of the means of finding financing so that both the management and the labor would not have to engage on an annual basis negotiation over the health insurance issue—clearly, there is enough money in the system, as I have indicated, the $850 billion we are spending, and the challenge is to figure out a way to tie those dollars to some other scheme, rather than the employment base.

So, rather than thinking in terms of, whether it should be 50-percent business, 50-percent employee, maybe we should look at other means. I know it is a tough one.

Chairman WYDEN. One of the areas that lots of small businesses have been interested in exploring is the possibility of workman's

compensation costs and possibly auto insurance costs being layered into the health system as a way to avoid duplication, and I'm trying to, again, hone this down in terms of the cost.

Have you done any analyses to indicate what it might mean for our State if there was an effort to merge some of these other insurances, particularly workman's compensation?

Dr. CHERIEL. Oregon has been lucky, I should say, in that it just received a grant, again from the Robert Wood Johnson Foundation, to look at that issue.

Through the Department of Insurance and Finance, there is a study underway looking at the benefits and problems, complexities, related issues in merging the medical component of worker's comp with the health component that businesses offer, and I think within, 1½ to 2 years, we will have a much greater understanding of the benefits and problems associated with that.

Chairman WYDEN. Go as fast as you can, Chad, because Mike Kopetski and I are going to have to vote.

Dr. CHERIEL. I will pass that on to the program coordinator.

Chairman WYDEN. Let me ask you just one other question.

One of the things that I think is especially troubling is how little information people can get about health care providers and various kinds of services.

I mean, to a great extent, you can get more information about what kind of breakfast cereal that you are going to eat in the morning than you can about a heart surgeon, and I would be interested as to whether the State wishes to support some new policies to make it possible to get more information, more specific information about providers and the outcomes that we see in the various procedures that they perform and whether this is a key part for Oregon of the health reform debate.

Dr. CHERIEL. Congressman Wyden, that is one of the most essential pieces that any new reform initiative should contain.

We talk about choice, we talk about imposing greater financial burden on the purchaser and on the consumers, and yet, neither one of those groups have adequate basic knowledge, adequate information, and adequate data to enable them to make a good decision.

You are absolutely right. We know about cereals or computers or calculators or microwaves than we do about the appropriateness of a variety of procedures, surgeries, medications, and it must be an obligation on the part of the proper agencies to offer that up so that consumers will become good consumers, so that there will be pressure on the providers, there will be accountability on the providers to make sure that they are delivering products that are efficacious and cost-effective.

Chairman WYDEN. Well, you have been very helpful, as always, and let us just say proceed as quickly as you can on a number of these studies, because I think, as Mike said, the President is going to make this proposal in the fall, Congress is likely to vote in 1994, and to the extent that you can arm us with good information in terms of what this means in the real world of small business in Oregon, it is going to be a lot easier to deal with this responsibly.

So, we will work with you often, I know, in the days ahead, and we will excuse you at this time.

Dr. CHERIEL. Thank you very much, and we will keep in touch with you as we come up with additional information and come up with additional analysis.

Chairman WYDEN. Very good. Thank you.

Let us move on to our next panel: Mr. Joe Gilliam, National Federation of Independent Businesses; Mr. Gene Wigglesworth, Midas Muffler & Brake Franchises, which is a firm in both Washington and Oregon; Mr. Kevin Earls, Associated Oregon Industries.

I cannot tell if it is of any significance that Kevin wants to be to the left of Joe Gilliam.

Gentlemen, we welcome all of you. Do any of you have any objection to being sworn as a witness this morning?

[No response.]

Chairman WYDEN. Please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. We welcome all of you. I particularly want to say hello to my friend, Joe Gilliam, a former intern in our office, who has gone on to, I know, great and exciting things here at home, and we want to welcome Joe and also appreciate Mr. Wigglesworth—I had a chance to read his testimony—and Mr. Earls has been doing good work in health issues for a long time.

We are going to make your prepared remarks a part of the hearing record, and if you could take about 5 minutes or so and just kind of highlight the principle concerns that you have, that would be helpful, and we will put your full statements in the record, and Mr. Gilliam, why don't we begin with you?

TESTIMONY OF JOE GILLIAM, NATIONAL FEDERATION OF INDEPENDENT BUSINESSES

Mr. GILLIAM. Thank you, Mr. Chairman. I am Joe Gilliam of National Federation of Independent Businesses.

I represent over 16,000 small businesses here in the State of Oregon. Over two-thirds of those 16,000 have less than 10 employees and do less than half-a-million dollars a year in sales, to give you an idea. We have members in every county, all over the State.

Well, in brief here, I am going to make a couple of comments about what we feel we have to get critically and from a philosophical view, particularly what you asked us to do, and that is we would like to talk about partnerships.

We need to come to the table and we need to do this, and after I make my comments, I am going to let my colleagues here from the business community talk about some of the key elements, and then, hopefully, in questions, we can—some of the questions you have already asked, we would like to flesh out some of our answers to that.

One of the key things you must do in this process—I have been at it for 5 years now with NFIB, have been in a battle over health care, and that is really too bad, because we have not even been to the table, but it has been an all-out assault by those who would benefit from the system to try to get small businesses to carry the burden and that is a solution to health care, and it is a tax assault, and so, we have had to be in a defensive stance for quite some time as a small business community just to try and protect our liveli-

hood instead of talking about issues of reform of the health care system.

Now, about half my members, 52 percent, currently provide health benefits for their employees. The other 48 percent do not, and the number one issue is cost, and that is what it comes down to, and the one issue we have not discussed either in the Oregon plan or nationally is the cost issue.

We have tried to get everybody paying in before we have addressed the cost issue, and that is the number one issue. It is not access, it is not small employers not being willing to participate. It is the cost issue.

We need to recognize that this is not just a business-labor issue; it is a societal issue, and it is an individual issue.

Anybody who is benefiting from the system also has a responsibility to contribute to support the system, and it does not matter if they are working or not working; if they are benefiting, they have a responsibility.

Now, we could talk about subsidy levels and how we get to that, but it has to be everybody in the group. We cannot target one little group, minority, and say you are going to pay for the benefits of everybody out here; it is your responsibility.

The responsibility is all ours as a whole. We are willing to participate in that, but we have got to change our focus, I believe, and really, it gets down to we need to be asked to the table and not treated as targets in this conversation, so we can be constructive and positive and be here with you.

We are very, very concerned about health care. It is our number one issue right now. Since we have solved the workman's comp problem here, at least for the time being, in the State of Oregon, health care moved right to the top of the list for small businesses.

I believe that we can get there if we get over these obstacles. We can come together and stop the political game-playing back and forth.

I believe, at that point, we start dealing with some of the issues that you are asking about, but that is a big, big step, politically, to get there.

You have these organizations, the National Chamber, ours nationally. We have 600,000 members nationwide who need to be at the table. So, we need your help in getting us to that point.

There are many pieces and elements of the Oregon plan that are helpful to small businesses, particularly the 1076 plan that was passed in the '91 session talking about guaranteed issue, guaranteed renewability, rate banding.

It is very difficult in how you set that up to make it work. There are some real principles there that you can bring together to make it work.

I will be available for questions, and I will open it to my colleagues for some other various comments.

[Mr. Gilliam's statement may be found in the appendix.]

Chairman WYDEN. Very good and a good way to begin this.

Mr. Wigglesworth.

TESTIMONY OF GENE WIGGLESWORTH, MIDAS MUFFLER & BRAKE FRANCHISE

Mr. WIGGLESWORTH. Thank you. Good morning, Mr. Chairman, Congressman Kopetski. I am Gene Wigglesworth, testifying on behalf of the U.S. Chamber of Commerce and the Small Business Council of that chamber, and because I live in the area, I have been asked to testify.

The U.S. Chamber of Commerce has some 206,000 small businesses in its membership nationwide.

First of all, I would like to State I am not an expert on health policy, but I own eight muffler shops in the area, and I have followed this issue for several years through my associations and memberships and also my personal interest as an employer.

Five of my shops are in Oregon—three are in the Portland area—and roughly half of my employees right now are on the Oregon side of the river.

I also serve on the board of directors of the Pacific Automotive Trades Association, which offers health insurance to its members, and as a member of that PATA board, I have worked with the brokers in working with plans and dealing with the issue of premiums.

I am also a member of that Small Business Council for the U.S. Chamber, and health insurance reform has been an issue on our table for a long, long time, and so, I have got that interest.

Both as a small business owner and a member of PATA's board, I am all too familiar with increasing health care costs.

In addition, as an employer whose employees have young families to support, I am concerned about the effects of these escalating costs on my staff.

I previously insured my employees a number of years ago through the Blue Cross/Blue Shield Program and, at that time, paid 100 percent of the cost for my employees.

Because of rising health care costs, I could not continue to absorb those costs because of the continued price increases, and the only way that we found that we could handle the increases was to deal with the issue of deductibles, and over the years, the deductible kept getting bigger and bigger and bigger as a way of maintaining premium control, and the last time I think I looked at it when we were with them, it had gotten up to around $500 per person per year as a deductible, and I knew that, in my employee group, I have a lot of young employees, some of whom are married with children, and they are not able to have large saving accounts standing by in case there is an emergency, and the large deductible would play a part in that.

So, I did some research and got involved with Kaiser, which is a health maintenance program, and went to all my employees in employee meetings for several weeks and discussed these issues and discussed the idea of moving to that type of a program where they would share the cost but also lower the deductibles or the portion that they would pay if they had to make an office visit or go into the hospital, and eventually, through those meetings, we had a vote, and the vote came out to go for that kind of a program, be-

cause they were scared to death of these increasing deductibles and what it would mean if they really did have an emergency.

Chairman WYDEN. May I interrupt you for a second? You actually put to your people for a vote the choices in terms of benefit packages, and they could factor it into all of the things that relate to wages and health care and how the company operates?

Mr. WIGGLESWORTH. Yes, and that was at a time when—I did not have a chance—and again, I have to run a business all the time at the same time, but I did not have a chance to go into lots of who was out there in the competitive world, and I think there are some HMO's now that were either in existence then or were not very competitive or whatever, but we did the best we could, and at the same time, when I instituted the move to a Kaiser-type plan and had the employees start to share some of those costs for themselves as well as their dependents, I was able to—and learned about through—actually, through the U.S. Chamber—the Section 125 of the IRS code that allowed me to deduct their premium costs from their gross wages before taxes.

Now, what I found out, though, in the years ensuing, is that lots and lots of small businesses are not aware of that.

I was also, at the time, as a side note, looking at the cafeteria kinds of things, because with young people and people who have children, they have other expenses that could work, but I ended up fighting for about 2 years, because part of that cafeteria plan has some characteristics for small business that are not conducive to our operation, and I ended up staying away from that and just working with Section 125.

My business experience with rising health insurance costs is indicative of the need for reform of the health care system. My written statement includes a number of charts that underscore the urgency of rising health care costs.

Most of these statistics have been widely discussed in recent months. They show how health care costs are escalating and that sort of thing and the kinds of data that we have seen here.

Additional charts bear out the impression that lack of insurance coverage is primarily a problem for small business workers and their families. I know that you have heard these, and so I will not go into them in detail. A lot of these people are employees that earn less than $7 an hour, for example.

In a company with thin margins, providing health insurance to these workers could or would increase labor costs by—a number of 22 percent was used, which could mean layoffs or business failures. I can speak to these things from a personal standpoint more often than I can from a prepared text.

Some policymakers have suggested that marginal companies, many of whom employ low-wage workers, do not deserve to be in business. That is an interesting judgment call.

Small businesses that do provide health insurance indirectly subsidize those that do not. When an uninsured worker gets medical care and cannot pay his bill, hospitals and doctors raise prices to other privately-insured patients to make up the difference. Mostly, these price increases are paid by a lot of small businesses.

Chamber members recognize that employers have a critical role to play in reform our health care system, and we have been at it for a number of years in various formats around the country.

We are in favor of a system that achieves affordable health insurance coverage by building on the strong current base of employer-provided health benefits.

The chamber seeks participation by all levels of society—Government, employers, and individuals—in a framework of managed competition. No one should be permitted to opt out of the system or its obligations, but no one should be ruined in the process.

Under managed competition, consumers and employers armed with objective information on price and quality would shop for health coverage, changes in the tax code would give people an incentive to choose cost-effective plans, and small businesses and individuals would pool their purchasing power to give them greater clout.

The chamber is convinced that health care costs can only be contained if everyone is in the system and playing by the same rules, but we recognize that some individuals and employers are unable to afford health insurance.

Chamber policy holds that individuals should be required to have insurance coverage, while employers should make insurance available to workers and dependents and contribute something to its cost.

However, the chamber will oppose any health insurance requirement that does not include adequate subsidies for low-wage workers and their employers. An insurance mandate that produces job loss and business failure is not a social gain.

The chamber favors purchasing cooperatives as a means of banding small businesses together for greater market clout, provided these pools remain focused on small business.

In this way, small business will finally have the leverage to compete against larger companies in the market for health insurance.

There have been some discussions of adding still another program to the reform mix by including the medical component of worker's compensation insurance.

While, on the surface, seamless coverage sounds appealing, the chamber cautions that any changes to worker's comp must preserve employers' incentives to maintain a safe work place.

In addition, employers must retain the ability to manage disability cases for maximum and timely rehabilitation, with an eye toward controlling indemnity costs.

In conclusion, the chamber is reserving judgment on the President's plan until the plan's details are publicly known. We look forward to working with you over the coming months to secure real improvements in the Nation's health care system.

Thank you for giving me the opportunity to testify.

[Mr. Wigglesworth's statement may be found in the appendix.]

Chairman WYDEN. Mr. Wigglesworth, very helpful and certainly innovative in terms of involving your employees so that the costs are really laid out in front of people, which I think we all know is one of the frustrations about today's health system, is so much of it kind of insulates everybody.

You have insurance companies. They say, well, insurance is taking care of it. What you did in your place is essentially to bring everybody in and allow people an array of choices and make it clear there is no free goods and we can all do this together. Very interesting.

Mr. WIGGLESWORTH. I might say that I have monitored the situation for the last 3 years that we have been in this particular program, and there seems to be pretty good satisfaction.

Now, keep in mind, though, that I have some employees that are young, that are single, that choose not to participate, they gamble, and then there are others whose spouses work for some other company and have partial coverage or something somewhere else.

Chairman WYDEN. We will have some more questions for you in a moment.

Mr. Earls, welcome.

TESTIMONY OF KEVIN EARLS, ASSOCIATED OREGON INDUSTRIES

Mr. EARLS. Thank you.

Mr. Chairman, for the record, I am Kevin Earls, representing Associated Oregon Industries, and I would like to thank you both for inviting me here today and giving me the opportunity to comment on some national health care reform ideas.

As you know, our focus is generally at the State level, and so, it is refreshing to be able to have some time and put some thought into the national plan and some ideas along that line.

In the request that I received from your office, I was asked to put together some kind of positive thoughts about positive elements of health care reform and some negative, perhaps things we do not want to see in the plan, and to that end, I have kind of created a little laundry list.

Chairman WYDEN. The negative is like this, and the positive——

Mr. EARLS. Actually, it is a little shorter.

Chairman WYDEN. Good.

Mr. EARLS. I ran out of time.

I think that there is broad-based agreement that we need a universal system, a universal health care system, to get everybody at the table, and having said that, we also, I think, need to recognize that we are not terribly far from that as a society.

We have a great aggregate number of people who are uninsured, but as a percentage, it is a relatively small number, I understand, about 13 or 14 percent.

So, we are providing coverage to a great many of our citizens through an existing system. It does, obviously, need some help to reach that last 13 or 14 percent.

We would like to see a cost containment approach based on competition among providers.

True economic competition is something that really has not been seen in the health care delivery system, and we believe that, by approaching national reform through the offering of prepaid capitated health care delivery systems, we can find a way to create a true sense of competition among health care providers where they are,

in fact, competing for market segments based on quality of service, price of the product, and the quality of the service itself.

We want to see a system that is built on the employer-based system. We think that the employer-based system is the appropriate port of entry, and it works well for many people in this country.

We would like to see continued efforts to promote State-level experimentation, as we have been involved in that here in Oregon.

We would like to see perhaps an effective test of any proposed national reform at a State level. So, rather than embracing a national reform package straight out of the shoot, we would like to see a beta test where we can work the bugs out.

Certainly, I think it would be everybody's expectation that, whatever system we develop, whatever changes we make, there will need to be continued monitoring and modification as it is implemented.

We would like to see a choice of providers or health care delivery systems made by the payers, so that the people who have the true financial stake in providing health care in this country have the ability to influence the systems that are used to contain costs.

So, while I know there is a great deal of anxiety in this country about being able to continue to see your own doctor, that discussion often overlooks the fact that that has a cost, and that cost is often borne by a third party.

We would like to see 100-percent tax deductibility for health care benefits for the self-employed.

Now, looking at a few things that we are concerned about, negative elements, we are concerned that a true mandate will cost jobs and jeopardize an already fragile economy at both the State and national level.

We are concerned about the kind of entitlement mentality that often encompasses the health care debate, the sense that health care is a right that every citizen has that is inalienable, but whose financial responsibility ultimately belongs to someone else.

We are concerned about a high-cost benefits package that might be unsustainable over the long term—we would like to see modest beginnings in terms of developing that benefits package—and our concern that much of the national debate that has occurred in the past year has really encompassed a very—from our perception, a very rich benefit package that does not eliminate much.

Again, we are concerned about the choice of a provider or a health care delivery system being dictated by those that have no financial stake in controlling costs.

We oppose the general top-down regulatory approach that has been used over the past couple of decades as an attempt to try and regulate both capacity and cost in this country.

We find very little record of success in trying to constrain costs in that method, and again, we would like to see an embracement of a more economically-driven model of competition.

Again, we would like to see the implementation of national reform that has a demonstration project attached to it, so that we can actually see the proof of the success and avoid some of the pitfalls that perhaps we have made with Medicaid and Medicare.

Other concerns: There is a lot of discussion about community rating. That poses some problems to the degree that we have self-insurance among large corporations and large trusts in this country. There are some adverse selection implications of that type of duality.

We also believe that community rating, while, I guess, theoretically, having a good deal of appeal, it also disadvantages the young and the healthier and perhaps the less-affluent in our society by having them, in essence, subsidize others that perhaps are not as aware of their own health habits, perhaps have higher incomes, or have self-limiting health problems that they have chosen to ignore.

I guess, in conclusion, I would suggest that we already have at least two national health care plans, Medicaid and Medicare, and that our experience in those areas has been less than satisfactory.

Perhaps it would be prudent for the Federal Government and Congress to consider implementing the reform concepts that are being developed now in the context of those two programs, so that we can build a level of faith among American business and American citizens that the Federal Government is up to the task of managing costs and providing health care through an entitlement-based program for the target audiences.

That concludes my remarks.

Chairman WYDEN. All right. Let us being with some questions. Mr. Kopetski.

Mr. KOPETSKI. Thank you, Mr. Chairman. I have a number of questions. Unfortunately, I have to leave at 12:30, and we have another panel, but I will try to be quick.

Mr. Gilliam, I appreciate your testimony very much. Can you provide the committee with a breakdown of your membership in terms of how they are organized as a corporation, or perhaps you already know, are they sole proprietors, partnerships, Chapter S corps, and C corps?

Mr. GILLIAM. Congressman Kopetski, I can get you the exact numbers. Most of our members, in the 80-percent range, are just partnerships and sole proprietors.

Mr. KOPETSKI. So, the deductibility issue is very significant to your members and a lot of small businesses in Oregon.

Mr. GILLIAM. Very significant.

Mr. KOPETSKI. We are at 25 percent, and our goal is to reach 100 percent, just as other corporations, or businesses, I should say, are treated.

Mr. GILLIAM. This session in the legislature, we did draft a bill to do just that at the State level, go beyond the Federal bill and go to 100 percent. I can tell you that the cost estimate on that was $50 million to just do it today in our State. So, there is a significant cost associated with it.

We had passed—to a certain level—we had passed a bill that would phase in to the year 2000, 10 percent a year, to the year 2000, to the 100-percent deductibility level. So, those are some of the things we tried.

Now, frankly, because of the budget considerations here in this State, we could not carve $50 million out of the budget to get it done.

Mr. KOPETSKI. We have some problems in DC with the budget, too.

Mr. GILLIAM. It is something that will be helpful and fair treatment for many that are self-employed. Even if they provide it for their employees, they can deduct theirs, but when it comes to them, they are taxed on the other 75 percent, which is something we ought to remember, too.

Mr. KOPETSKI. Let me ask you, how much difference would it make—we saw the charts earlier from Dr. Cheriel. Would there be a massive change with the small businesses, under five employees for example, under 10 employees? Would they go out and provide health care coverage to their workers if there was this 100-percent deduction?

Mr. GILLIAM. Congressman Kopetski, I do not think there is any one answer to that final 15 percent that is uninsured that causes a landslide. You have to take a little piece of the pie at a time. There's small populations that have different types of problems.

I think you get a significant portion of people who would start buying health insurance for themselves, the small people coming out of the blocks that would be able to.

I do not think you would see a landslide, because the people we are talking about—it is still a cash-flow issue of how much money is available.

Twenty-five percent today helps, but 100 percent would help a few more maintain it, and in the economics of today, where the costs are rising so much, a movement to 100-percent deductibility would probably help maintain more people who eventually may start losing their health care because of the rising costs.

So, you are going to help stem the tide, and you are going to bring a few more people in. I still think it is a very worthwhile pursuit.

Mr. KOPETSKI. OK.

Mr. Wigglesworth, I really appreciated your testimony, especially taking note that you mention that a lot of your workers are $7-an-hour-type workers, and so, you are a small business that—your workers are receiving relatively a lower wage, yet you are providing a health care option to them.

You mentioned that the younger workers—a lot of the younger workers—I assume they say, well, I am young, I am not going to get sick, and, what, I would rather have more money in my paycheck? Is that what they say?

Mr. WIGGLESWORTH. Well, yes, in the sense that a portion of the premium, they would—roughly a third. I pick up the cost of about two-thirds of the individual employee, and that is a few more dollars in their pocket, yes. In some cases, it might even buy more cigarettes.

Mr. KOPETSKI. Right. Do you think that is a big problem in our society with our younger people, that they say, well, I am young, and I am not going to get hurt, or I am not married, I do not have children to worry about, and therefore, I would rather have the money in the pocket rather than provide the health care coverage?

Mr. WIGGLESWORTH. I do not have any statistics nationwide, and I do not have access to that. I am sure there are groups that might

be able to do that. Individually and in small companies that I know of, I think it is a point.

I would say, in my group, I have a lot young males, and they tend to think that they are——

Mr. KOPETSKI. Immune from everything?

Mr. WIGGLESWORTH. [continuing.] immune from everything. So, they sometimes pass on that.

I do not know that it is always thought of as a dollar issue, although in some cases it is.

Mr. KOPETSKI. If Government was to require coverage, hopefully there would be some benefits, credits, et cetera, for small businesses—and we would impose that—should it also be a requirement, therefore, on the employee that they do have coverage, that they take advantage of the coverage?

Mr. WIGGLESWORTH. Well, I think, in the chamber policy, it says that. They feel, the chamber feels that everyone should participate. I personally feel that way, as an employer.

When we had our vote and went to the Kaiser-type plan, it was by getting everyone involved in the process and trying to get as much information out there, so that they could make a wise decision.

Now, since then, turnover has brought in new people, and they make decisions individually, but we still try and give them as much information as we can.

Mr. KOPETSKI. Joe, in terms of some of these other ideas out there—for example, with the worker's compensation issue and rolling in a 24-hour service policy for businesses—what is NFIB's thoughts about that?

Mr. GILLIAM. We supported the—we got some money to do a pilot project. We thought this was a good idea, because our concern is this: The biggest issue here is—the idea is do cost savings and having good insurance, if you could meld the two together. However, there are significant differences in how you process the insurance and the medical claims for worker's comp than you do for just regular indemnity claims.

Worker's comp you need to reserve for a lifetime benefit. If I am hurt on the job, I have a right to aggravation benefits and disability payments out to the end of my lifetime, where in the health insurance field, if I get a broken arm and I am with Employer A and I move to Employer B, there is no carryover.

So, there is a big issue of how you restructure the whole worker's comp program and you talk about lifetime benefits, and to get it all under one roof to do the insurance.

If you do not do that, you are still processing two different types of insurance claims, and I do not think you ultimately save yourself a lot of money in the process.

Mr. KOPETSKI. Well, I think we are bright folks, and we can separate out the aggravation issues from the medical—get the broken arm fixed. We are seeing that the cost of worker's compensation health care has skyrocketed even higher than other segments of health care premiums in this society, and perhaps that is because we do not monitor or regulate, put as much pressure on the worker's comp medical system as we do, let us say, under the Medicare

system. I think that is a fruitful area that we ought to investigate at the Federal level.

Kevin, I wanted to ask you about managed competition and your support of that. Everything I have read about managed competition says you need a population base of about 350,000 before this kind of competition kicks in.

Now, the problem I have is I do not have one community in my district with 350,000 people in it. What are we going to do about that?

In other words, I am a rural legislator. The largest town I have is Salem. It is 100,000 people. In Oregon, we think it is a big city, but compared to Los Angeles and New York, it is not.

Mr. EARLS. I guess, first of all, with regard to the concept of managed competition, I think that that is a term that has come to mean a great number of things to a great many people.

With regard to using a different type of delivery system to meet the needs of rural Oregonians, say, I think that what needs to drive the response to that issue is getting provider systems to compete, on whatever basis in local communities, on a basic level of benefits, so that they are competing on price and quality and service on the same package, and allow them to use their own market incentives to provide access to those communities.

Certainly, there will be exceptions to that, but I do not think, for instance, Salem would be an exception to that.

Salem is geographically close enough to a larger market that it can provide access to a large number of services that do not need to be provided right at the local level, but primary care services certainly could be.

So, the most direct answer I can give you is I think that that—the nature of the delivery systems is changing and that we should foster that change by allowing provider groups to respond based on a kind of a prepaid capitated system of a basic package.

Mr. KOPETSKI. Let me just kind of make a comment for all, and if anybody wants to respond, they may. One of the other initiatives that the President has set out for us as a Nation is welfare reform, and I am involved in that on a subcommittee that I serve on in Ways and Means.

One of the barriers, we know, of getting people off of welfare is the fact that why tell them to go to a job or encourage them to go to a minimum wage job or even something for $7 or $8 an hour if there is no health care coverage attached with that job, if they are better off, at least in taking care of their kids if nothing else, if they stay on the dole system, just because they have a medical card.

Mr. EARLS. Well, I guess my first response would be, unfortunately, being below the Federal poverty level in this country, it does not mean that you have coverage through Medicaid, for instance.

I think, in Oregon, we have about 50 percent of our below-Federal-poverty-level people covered. So, the first dynamic is do they really have coverage in the welfare system? Many people do not.

With regard to moving them into the private-sector employment arena, I think that there is an element of financial need that needs to be evaluated both on the individual level and on the employer level.

I think, certainly, that the best indicator of intent is that we have a health care system in this country in which employers largely voluntarily offer health care benefits to their employees, and they provide a great deal of the health care benefits in this country within their ability to do so in a voluntary system.

So, if a system can be designed at the State or Federal level that provides some subsidy to both the individual and employer to help them meet realistic financial obligations, then I think that you can move people from a poverty situation into private sector employment, but the premise that they have coverage because they are poor is not one that I see actually being in place.

Mr. KOPETSKI. Joe?

Mr. GILLIAM. I think we should look at the benefit level and decrease the benefit level but expand coverage to a higher number of people at the Federal poverty level, because currently, we are covering about in the 50th percentile someplace, and expand Medicaid benefits up to 100 percent of poverty level but provide less benefits. That is a tough choice but one that needs to be made.

I think, beyond that, when you get above 100 percent of poverty level and you have people going back into the work force and you want them to have an incentive, there are several ways to subsidize the cost of health care, and one would be to allow the individual or the employer to pay the State's share of Medicaid and still make it available from 100 percent—you get to pick a number—to maybe 200 percent of the poverty level, and you are still paying into a Medicaid premium, but it is going to be the individual or the employer, and at 200 percent of the poverty level, the subsidy is waived, and they are required to buy health insurance on their own, but their income is such at that point that that may be a societal decision to be made, that you are required to have health care, and either you get it through your employer or you get it on your own, and your purchasing groups may come into play at that point.

Mr. KOPETSKI. My final question is, should we distinguish in terms of the kinds of businesses and profit margins in looking at any kinds of Federal health subsidies, tax credits, et cetera, if we impose health care coverage? For example, the retail margin is much smaller than the financial service margin. Should we distinguish between industries at all?

What the President is looking at, as you are aware, is an 80/20 employer/employee split and a cap based on profits, and I was wondering if that should be different for different kinds of industries. That is my final question.

Mr. GILLIAM. I think you get into a real shaky area when you start doing that. It is very tough to distinguish, even in one industry, who has the ability to pay and who does not, and it also gets into a lot of game-playing, like what do I try and keep my profit margin looking like and use the tax code to do that.

I do not think focusing on those types of issues in trying to get coverage for people really is worth it. I think you have got to look at overall cost.

I am advocate of the individual. You are going to have responsibility, so you are going to get in the system, and you cannot get out, and you are going to make that determination, so you will have a mandate, at least on the individual.

That person now has a cost for health care, and they are going to go to employers who will help cover that cost, and the only way an employer is going to be competitive in the labor marketplace and stay in business with good labor and attract the right people is they are going to help pay for my cost.

That is the way to go, rather than trying to divide particular industries or size of business, because it is real tough to do that, and they are kind of antigrowth measures. If you say it is 25 employees or less, I am not going to hire 26 or else I am in a new category.

Mr. EARLS. I have a little different response. If I can kind of reframe the question in the context of trying to reach the remaining uninsured, what I would suggest is that we need to kind of reexamine our assumptions about the remaining uninsured market.

Obviously, many of those people who are uninsured are reachable, because they are below the Federal poverty level.

So, if we expanded the Medicaid Program at the State and Federal level to reach everybody below the Federal level, we would go a long ways to reaching the neediest people, and then, if you take a segment of the market of the uninsured and look at what their incomes are, I would pose the question to you: At what level of income should an individual be required to provide health care coverage for themselves and their families, because I am sure you are aware that there have been studies that show that a great deal of the uninsured have incomes of $20,000 or above and certainly have the means to meet much of their own health care needs and are making conscious decisions not to.

If we could take care of the very poor below the Federal poverty level, through existing programs, and implement a requirement that obligated individuals that have the financial means to provide coverage for themselves and their families first and then reexamine where we are with the remaining uninsured, we might come up with a different strategy.

Mr. KOPETSKI. Thank you.

Thank you, Mr. Chairman.

Chairman WYDEN. Well, all of you have been very helpful, and obviously, this is the key to getting health reform done properly.

I mean I am of the view that, if Congress, in the spasm of activity, ends up putting your folks out of business, we are crippling—if we are going to have fewer jobs, it is going to mean fewer people have health insurance, and we are just going to be further back in terms of the task ahead, and you all have been very conciliatory and tried to put on the table a variety of ideas, and let me just ask you about a few others.

What about the matter of some employers subsidizing other employers, because I do not think there is any question that Mr. Wigglesworth, for example, is subsidizing other employers.

I mean we know for a fact that employers like Mr. Wigglesworth that are working their heads off trying to have a good work place and a good job and involving your employees like you do, have a benefit package that is the basics, prevention-oriented, usually has a co-pay, something of that nature, and yet, there are people down the street who, for one reason or another—and I share Mike's view that most employers want to do the right thing, but for one reason or another, they are not covering their people, and so what hap-

pens is those employees get sick, too—I mean they cannot avoid human nature—but they go a hospital emergency room.

So, Mr. Wigglesworth pays for the person down the street, and not only does Mr. Wigglesworth pay for the person down the street, but Mr. Wigglesworth pays at the most expensive end of the health care system, pays for the hospital emergency room.

So, my question, I guess—start with you, Mr. Wigglesworth—is what do you all think ought to be done, if anything, with respect to this issue and whether, if done well, with the cost containment that Joe Gilliam correctly mentions, whether some kind of mandate might be fairer for employers like you than the current situation.

Mr. WIGGLESWORTH. Well, the word "mandate" scares a lot of small business people; at the same time, I understand what you are driving at.

Chairman WYDEN. Well, call it—let us abolish the word "mandate." Let us call it "shared responsibility," because I think Joe Gilliam puts it correctly and I have heard a lot of the business groups say that, whether some kind of requirement for shared responsibility would not be fairer to employers like you who, as far as I can tell, have to pick up some of the bills for other employers.

Mr. WIGGLESWORTH. I would agree that, many times, we small business people are not playing on a level field, and there are those who choose not to compete for the employee with benefit packages and that sort of thing.

What the word is, "mandate" or otherwise, and how it comes out, I would hope that the word "fairness" would be brought about for all concerned, and I would agree, also, with the idea that, if you get more of us involved in the process, those of us who have to meet that payroll, that have to look at the issues of cash-flow—and I am in a very seasonal business, believe me, because when it comes winter time and I have still got to meet that cost for health insurance, I can tell you, on my payroll, who sacrifices the pay first to maintain those kinds of obligations, and it is very simple cash-flow management: I do not get paid in the winter time or in those times when we have economic situations.

So, I would say I think there are methods out there. What word you use—there are methods out there. If we get small business people involved in the process, we can come up with an answer.

Chairman WYDEN. Let me read you what the head of the Small Business Legislative Council said about a couple of weeks ago at a hearing I was in back in DC. This is a group—I think Joe knows them—they have got 100 trade organizations.

They said, "If, on a basic minimum health care program, the employer paid 50 percent and the employee paid 50 percent and into that program the health part of workman's comp was covered, perhaps that would be a workable compromise."

Now, you are a business out in the real world, not somebody who has got to testify in DC. Does that strike you as being in the ball park of something that you could find acceptable?

Mr. WIGGLESWORTH. You can fish for numbers anywhere in the system.

I am paying, right now, roughly two-thirds for my employees, operating in two States that have two different views of how we are

going to approach this, and in the Washington bill—and I do not know it verbatim, but what is coming at me is 100-percent coverage, apparently, for my employees and their dependents, and it is going to include dental and a few other things that I have penciled out over the years and cannot afford, as a small business person.

If I am shackled with that, then I am going to have to look at a budget, decide what goes and what stays and look at pricing of my products and services, and so, I see some of these issues being related to an inflationary-type spiral if it is mandated and we do not have some input on how much we can afford.

Chairman WYDEN. Let us move to Mr. Gilliam, then, because I think that he is correct, and Mike Kopetski made the point in his opening statement that, if you do not have cost containment, all of the rest of this is really not going to do it.

I mean cost containment, dealing with these kind of underlying forces that are driving up health bills, is the key, and we can have any kind of shared relationship or shared responsibility or whatever we want to call it, but you have got to have cost containment.

Mr. Gilliam, what would be the best set of cost containment tools in NFIB's—I understand that you all have been supportive of the purchasing cooperatives as a way to pool bargaining power, and Mike and I have been interested in that.

What else would be useful to your people in terms of the cost containment hammer that we all recognize as such?

Mr. GILLIAM. The key element, Mr. Chairman, has to be some competition amongst the providers. There has to be some type of incentive for them to have to come up with the best price, and I know it is a broad concept.

I share the same concerns that Congressman Kopetski does. That does not work in Burns. It does not work in Baker. You do not have the same systems. So, you are going to have to come with another concept of competition.

What is the incentive for a carrier or an insurance group, an HMO, to be in those areas? You are going to have look at the competition issue.

If you just go out and say we are going to have a mandate and you have to pay, you are going to have the same headaches and problems you have had with all the worker's comp systems around the country, because there is no pressure, there is no consumer pressure involving the purchasing of that benefit to say I want to control those costs.

Now, the unions finally got on board here a few years ago in worker's comp through negotiations for wages. Comp premiums were so high that wages were being suppressed, and that was something they could see every day.

We need that same type of pressure from individuals and employees and employers so they all have the same common interest in keeping the cost down and forcing providers to be competitive. That is where we start building a structure.

Now, it be that alliances are part of that, but we have to build it that way so everybody who is consuming is on the same side in dealing with the providers and the carriers.

Chairman WYDEN. I think there are actually some encouraging developments coming in terms of getting out some of the tools for better competition.

I know that some of the business coalitions around the country are going to these reports cards, where they are evaluating providers; getting out, for example, information about hospitals and doctors; who has, for example, a high percentage of kids that are being immunized and who has a low percentage, and I think this is an area where there can be a good effort developed to try to inject some competitive juices into the system.

Mr. GILLIAM. I believe that, in our last bill, the Oregon health care plan, 5530, we had a scorecard, that scorecard included in the bill that should be developed.

I think it makes common sense that they should be developed on hospitals and providers, so we can see where the money is spent and who is doing what. I think it is important.

Chairman WYDEN. Mr. Earls, I thought your testimony was very helpful. I really do not have any specific questions for you at this point. I think you are going to get at least a portion of your desire in terms of the role of the States.

I think that President Clinton, with his background as a governor, is inclined to give the States a very wide berth in terms of implementing, a national plan.

My sense is that, if a State, for example, wants to opt out of the national plan and will say, look, we can meet the national requirements in this bill, we can offer the national benefit package and the like, I think the President is going to be inclined to give the States a very wide berth, and that could, of course, fit well for the Oregon plan, which I will tell you, my own review is that Oregonians are going to be amazed when they see the President's proposal, because I think the President's proposal is going to have a lot of what we have been working on in Oregon.

It is going to focus on prevention, it is going to have a basic benefit package, utilize HMO's where possible, although Mr. Gilliam is right, it does not work in Burns; I think expanded use of physician assistants, nontraditional practitioners.

I think Oregonians are going to be amazed at how many similarities there are going to be between what we have been working on and what you have.

So, more than anything, I think we want you to know our door is open. We are going to be interested in your input.

Doing this part of health reform right is, in my view, going to be as essential as anything else to getting a good bill passed. So, we need your ideas and input, and we'll excuse you at this time.

Our next panel, additional small businesses to give us some reports from the front line: Miriam Selby of Micro One, Scott Laney of Griffith Rubber, Margaret Brooks of Brooks Temporary Services, and Gene Sayler of Sayler's Old Country Kitchens.

Folks, we thank all of you for your patience, and certainly, 2 hours is patience by anybody's standards, and we do swear all witnesses who come before us. Do any of you have any objection to being sworn as a witness?

[No response.]

Chairman WYDEN. Please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. We are going to make your full remarks part of the hearing record in their entirety, and it would be great if you could summarize your principle concerns.

I know that it is almost a compulsion at these kinds of things for all of us to read our statements to each other, but if you can just highlight the principle concerns that you have, it would be great, and let us begin with Ms. Selby.

TESTIMONY OF MIRIAM SELBY, MICRO ONE

Ms. SELBY. Good morning. Thank you for inviting me.

I appear as a small business owner in support of a rational and good cost-effective system, but I am in opposition to a mandate, or you can call it shared responsibility, but it sounds like a duck to me, and so I call it a mandate, that small businesses pay for providing health care, and I just want to give you a case study, and I am just one small business owner in Portland, Oregon, and—just so that you really understand how it impacts our company.

I am a co-owner of Micro One, a 7-year-old computer consulting and programming company. We have 7 to 12 full-time employees and a network of contract programmers, and we have no health insurance.

We actually do not even qualify to get health insurance because we have a difference of opinion as to the type of health insurance that we want. Some people want Kaiser and so on, and also, we had an employee who had a preexisting condition. So, we would not qualify, and also, we want 100-percent coverage of all people, and some people wanted to opt out and so on.

So, for a variety of reasons, we did not even qualify, and I am sure that will change with the Oregon health plan being enacted, but anyway, employees either have no insurance or they pay for it themselves or they are covered by their spouse's insurance.

Now, the work that we do is based on contract. We have contracts with business and contracts with Government, and our workload, consequently, and hence our ability to earn revenues, fluctuate because of that.

So, sometimes, when contracts are completed and new contracts are slow to get going, we will have a real slow time, and our cashflow suffers, and so, this is when we really cut down cost and cut out all unnecessary expenses, and sometimes the owners forego getting paychecks or they get reduced paychecks, which is what a lot of small businesses I am sure do, but the margin is so slim that our business is such that there is never a time to pay bills ahead, and so—or saving money to pay for health insurance in the future.

So, it is these lean times that I am concerned about, because health care is not something you can say, well, we can afford it this month, but we have to stop it for 2 months, and then we can pick it up again.

So, that is the concern I have, of how you keep it once you have started it, and currently, that is the reason that we do not even offer it.

So, our choices—if it is mandated, our choices are to let people go, reduce salaries or delay giving raises, or increase the hourly

rate that we charge to our clients. None of those are very good choices.

It hurts morale, it impacts our competitiveness with other people, and in other words, it really affects our own profitability and our own ability to stay in business. So, those are my main concerns.

The second reason I do not support mandated health care cost for business is that it hides the cost—the issue of cost containment, and I am concerned that it thinks that we have solved the problem by mandating that the businesses pay for it and we do not do anything about cost containment, and I know there has been a lot of talk about that, but if you do not deal with that issue, there is not going to be any health reform in this country.

I do favor a single-payer system, an American version modeled after the Canadian system, and I know that you have had a lot of proposals presented to you about that.

I would favor the one that is simple and the most cost-effective and still provides quality care, and I urge you to ignore all vested interests in designing the best possible health care system for America.

Thanks.

[Mr. Selby's statement may be found in the appendix.]

Chairman WYDEN. Ms. Selby, thank you, very helpful and very important, because what happens to businesses like yours in Oregon and elsewhere is going to be key, and I will have some questions, and I know Mike will have some in a moment.

Ms. Brooks.

TESTIMONY OF MARGARET BROOKS, BROOKS TEMPORARY SERVICES

Ms. BROOKS. Thank you for having me. I am not speaking for any organization, just for our small business and my own thoughts.

I am originally from Canada. So, I had that health care all the time, and so, I believe that universal health care is essential, and I believe we should start with that premise.

Businesses do pay already for high insurance premiums due to cost shifting, and also, one of the things I did not mention and note, I have been unable to change coverage since I started, since one of my employees had cancer.

I now can get no coverage but the coverage I have. I either have to get rid of it, reduce what I pay and what the employees pay, or there is nothing else I can do. I am stuck now. I have no competition.

I believe that employers and employees should share the health care costs for medical coverage. The cost should be collected, I believe, something like FICA, Medicare, somehow, so it is a shared cost and that everybody does have to pay for it if they are working, no matter how much they work. If they work a few hours a week or if they work a few hours a month or however they do it, their wages will go into part of the cost.

I believe that, as far as Medicare/Medicaid—and worker's compensation should be rolled into the program. Medicare is already

there as a cost-sharing situation in our wages. So, I believe that all those costs should be rolled in.

I had not thought about automobile costs and medical until today, but I think that probably could be looked at.

As far as worker's comp should be concerned, I think that safety and job loss should still be covered under worker's comp. The safety issues to be sure employees are being safe and job loss should be covered under workman's comp, but obviously we will have to do some additional revenue to cover people who are not working, and I will leave that to your judgment to figure out those problems.

Cost containment is essential to any health plan. Preventive care such as prenatal care and immunization will save money. Any Government agency that is currently doing anything to do with health should probably be rolled in.

So, all costs regarding medical should all be rolled under one plan, under universal care, to eliminate duplication of services.

The system itself and how it looks when implemented is critical to the success of health care reform. When implemented, it must be easy to use for the health care provider, for insurance companies, and for patients.

I think it will help the portability of employment in this country. I work with a temporary service agency, and if large companies lay people off, temporary services and other small businesses are employing people.

I believe if people have portability of health care that they will be more likely to take risks and move. I think small business people will benefit as people become more portable in their employment needs.

Thank you.

Chairman WYDEN. Thank you, Ms. Brooks. I will have some questions in just a moment.

Mr. Sayler, welcome.

TESTIMONY OF GENE SAYLER, SAYLER'S OLD COUNTRY KITCHENS

Mr. SAYLER. Thank you, Congressman.

Chairman WYDEN. A Third District business——

Mr. SAYLER. Yes. Thank you.

Chairman WYDEN. [continuing.] of longstanding and good cuisine.

Mr. SAYLER. Thank you so much. I appreciate your invitation to testify, and it is nice to see you again, and Congressman Kopetski, who I had the honor to serve up in the Oregon legislature.

I am here today representing the National Restaurant Association, of which I am a member of the board of directors and represent the State of Oregon on the National Board.

Restaurants across the country have experienced double-digit inflation in premium costs and cancellations and denials of coverage.

However, with all of this recent experience, what frightens restaurants across this country and the National Restaurant Association, representing the most, is a benefits mandate. The National Restaurant Association is in alterably opposed to a mandate on health insurance.

In efforts to substantiate our reasons for this, the National Restaurant Association has done extensive research on what our members provide and do not provide to their employees, and here are some of the initial results.

Among restaurants with sales of $1 million of more, well over two-thirds offer benefits to hourly and salaried employees. Most small restaurants with sales under $500,000 do not offer health insurance. Of those restaurants who do not offer a health plan, four out of five indicated they would if rates were lower. Almost two out of three surveyed restaurateurs said they cannot pass on the costs of employee health insurance to customers in the form of higher prices.

There is an attachment in the back of my testimony that I think is very graphic. It shows a $750,000 restaurant, table-service restaurant, with a 7- to 9-percent payroll tax to cover insurance, goes from a $12,000 in a year to a over $2,000 loss.

I would tell you that the reason we see it this way—it is very difficult in our industry to pass along price increases.

Customers in our industry are extremely sensitive to price increases, and because it is an industry made up of a huge number of small businesses—70 percent of them, I think, under $500,000 a year—it is very sensitive to these sorts of things.

Along with the research, the NRA polled 1,000 adult restaurant workers, and the conclusion of that poll was they do not believe in a health mandate either if they feel there will be a cutback in their hours or job layoffs.

This whole concern really deals with cost, and let me give you some characteristics of our industry.

As I said, first, we are dominated by small business, over 70 percent under $500,000.

Second, our profit margins are very slim.

Third, we employ an extremely diverse work force, more teens than any other industry and 59 percent of our workers are women, including 70 percent of the food service supervisors, 67 percent are unmarried, and 76 percent live at home with their parents or relatives.

We are very labor-intensive. Currently 9 million Americans work in food service, projected to be 12 million by the year 2005.

This combination of characteristics means it is particularly vulnerable to labor cost increases while at the same time lacking options for absorbing those cost increases.

What the National Restaurant Association does support is universal access to coverage, and we feel the best ways we can do that are:

First, support the establishment of health insurance purchasing pools that would help small business and uninsured Americans buy quality health insurance.

Second, we support tax changes that give sole proprietorships, S corporations, and partnerships a full tax deduction for the cost of health insurance premiums. More than 4 out of 10 eating and drinking places fall in these categories.

We also support—I think this is important—we also support tax changes to limit employers' tax deduction and employees' tax exclusion for excessive health care costs. Unlimited tax advantages

have contributed to the growth of unnecessary medical care and wasteful spending.

Third, we support reforms in the insurance market for small businesses, so employers and employees are guaranteed insurance coverage that cannot be canceled on a whim.

Fourth, we support a Federal preemption of costly State laws that require even basic benefit plans to include extensive coverage.

Fifth, we support reducing paperwork by creating a uniform electronic claims system.

Sixth and finally, we support reforms to the medical malpractice laws so that doctors will not resort to excessive tests and procedures solely to shield themselves from lawsuits.

I think, in conclusion, let me say that thousands and thousands of small restaurants across this country would love to be able to provide health insurance to their employees. If there is some way to cost-contain this, open access, we wish you all the very best in that.

Thank you very much.

[Mr. Sayler's statement may be found in the appendix.]

Chairman WYDEN. Thank you, Mr. Sayler. It is sort of like, wishing us good luck before a dual or something like that.

Let us proceed to Mr. Laney. We welcome you.

TESTIMONY OF SCOTT LANEY, PRESIDENT, GRIFFITH RUBBER MILLS

Mr. LANEY. Mr. Chairman, thank you.

Representative Kopetski, thank you for inviting me.

Griffith Rubber Mills, who I am the president of and am here representing, is a slightly different case study than some of the other private sector people we have heard today. Griffith Rubber Mills is self-insured. We offer both optical, dental, and medical coverage.

We have 450 employees. Our current cost per year per employee is $1,155. That is competitive in many respects, certainly in respect to the national average that we keep hearing talked about.

Griffith Rubber Mills and myself are concerned if that is our benchmark, if the national average——

Chairman WYDEN. Can I interrupt you just for a second, Mr. Laney? You said you put in $1,155 per employee. What does the worker put in as their share?

Mr. LANEY. OK. That includes our workers' co-payment. That is our total cost. At Griffith Rubber Mills, the co-payment for a family, a typical family, is $11.90 a week.

Chairman WYDEN. So, a year—it is about 50/50. Griffith Rubber is about 50/50?

Mr. LANEY. Yes, it is.

Chairman WYDEN. All right.

Mr. LANEY. We are greatly concerned that a national health plan may end up costing us more than we are currently paying. We have done a tremendous amount of work.

Let me say that I believe manufacturers, in particular, do a poor job in a couple of areas: Educating people how to use their health

system to their advantage from a cost standpoint and in preventing illness to begin with.

I think, in those two areas, many of the high costs of health care fall squarely on the shoulders of manufacturers themselves, and we missed the boat, and we are playing catchup, and I think the companies that do a good job in those areas, you can certainly see it in their financial results. You can see it in their costs.

We are also concerned with any opt-out provisions that there may be in the plan. It seems to me that, if the plan is designed to help smaller employers—and certainly, much of the emphasis is on smaller employers, the two- to five-employee operations—if the large employers, the GM's and Ford Motors, can opt out, the companies that are left are companies like mine, and the costs fall squarely on our shoulders.

Chairman WYDEN. So I am clear on that, your concern is more in terms of the opt-out as it relates to letting big employers out, not this matter of States being allowed to——

Mr. LANEY. Exactly.

Chairman WYDEN. OK.

Mr. LANEY. I am concerned about the private sector opt-out. I believe, if we are going to do it, everyone should be part of the pool.

I think there is—not from a congressional standpoint but from an administrative standpoint, I think there is a lack of understanding of the ability of manufacturers to absorb some of these additional costs.

Therefore, I would strongly urge you to get as many business people involved in the formulation of any product that comes out of Washington as possible. I think it is always safe to say that business people are best equipped to make decisions that involve business.

It scares me somewhat that we have people outside of the industrial loop that are making some of these financial decisions, at least now. If I could be king for a day, I would certainly try and get some business people involved.

Those, in a nutshell, are our concerns. We do not feel that a national health plan, so to speak, is in essence a poor idea. We feel that there are some very good concepts.

Mr. Chairman, you earlier alluded to the fact that we are paying for—companies that offer insurance to their workers are paying for, in some respects, employers that do not. I very much agree.

It is hard to say that a certain percentage of our overall costs are related to that, but I think that, although it is not really an acceptable given that private sector employers need to provide insurance, I think it certainly works to the disadvantage of those that do to have so many that do not.

Chairman WYDEN. Well, thank you. If this was easy, we would not have our friend Mr. Sayler say good luck.

Mr. LANEY. Right.

Chairman WYDEN. It is going to take a lot of work and a lot of counsel, a lot of thrashing through the various kinds of options.

Let me let my friend Mr. Kopetski start our questioning for this round.

Mr. KOPETSKI. Thank you, Mr. Chairman.

Both Ron and I have agreed that, once the President has revealed his plan, we want to hold extensive hearings in our districts and solicit advice and views from consumers, the general public, but also the providers and businesses and workers, everybody that is going to be impacted by that.

This is a decision that is monumental, I think, for our country in terms of the humanitarian issues involved but also our economic competitiveness.

On a world scale, it is costing us more to manufacture a car than it does the Japanese, and a good part of that reason is because we are paying a lot more in health care costs for the workers who build that car than the Japanese are paying or than the Germans are paying. I am sure, in the rubber industry, you find the same thing.

So, there are many reasons to attack this issue, and we must do so. It is one, though, that Washington, DC, and the beltway should not make isolated within that circle.

We have to come home and get a good understanding of what works, what are the pitfalls, and most important, I think, is how do we make those things that are the pitfalls better and make it work.

So, we are going to be hosting a series of meetings, public and private, to solicit these views, and all of that will begin probably in October or November, for sure.

I just have a few questions.

Gene, one of your statistics that you gave was that about—if I understand it right—about 40 percent of the restaurants are sole proprietorships or S corps.

Mr. SAYLER. More than that, Congressman. The majority are sole proprietorships, S corporations, or partnerships.

Mr. KOPETSKI. So, at most, they can only take the 25 percent.

Mr. SAYLER. That is correct.

Mr. KOPETSKI. Do you know if your industry could provide to us the figure—of those that are regular corporations, what percentage of them provide coverage to their workers, health care coverage?

Mr. SAYLER. I think I addressed that in here. Four out of five, I believe I said, offered—had access to health care coverage, employees did, the larger corporations, I think.

Mr. KOPETSKI. I see. OK.

Mr. SAYLER. If I could just use my own company as an example——

Mr. KOPETSKI. How many employees do you have?

Mr. SAYLER. We have 160 employees, not nearly all full-time. That is between our east side and west side locations—90 in the east, 70 in the west.

Mr. KOPETSKI. OK.

Mr. SAYLER. Of that 160, a significant percentage are very young people, 16 or 17. We do not offer health insurance to them.

We offer it free of charge to all of our adult employees who are over 18 years old, with one provision. They have to work 100 hours a month. That works out to about 22 to 23 hours a week.

If they do that, free charge, Blue Cross/Blue Shield. They have a choice of traditional or HMO. Interestingly, about 90-some percent of them opt for HMO.

That would be very similar to what it is in the corporate side of it, I think. We probably are fairly representative of that.

Mr. KOPETSKI. You are a corporation?

Mr. SAYLER. Yes.

Mr. KOPETSKI. OK.

In terms of the part-time workers, if they wanted coverage, could they get it if they paid for it?

Mr. SAYLER. Yes, anyone could.

Of the 80 that do not have it, probably 25 of them are children—I will just call them children—who have it through their parents.

Of the other 55, most of them are waitresses who have far better plans through their husbands, who may work for Griffith Rubber Company or something like that, and choose not to have it.

Mr. KOPETSKI. Thank you. The employees that turn it down, do you think, generally, it is because they have coverage some other place?

Mr. SAYLER. Exactly. A lot of our young men, cooks in their 20's, I think almost all of them have it, unless they have it through their wife's employment or parents still or something.

Mr. KOPETSKI. OK.

Ms. Brooks, what percent of your payroll goes to pay for health care coverage?

Ms. BROOKS. Well, a lot of my employees are not covered, because they are temporary workers working a week here, a week there, a day here, and a day there.

So, there is almost no way to cover them, to get coverage properly for them, because they are in and out of the system so quickly.

That is a concern that I have, that I wish that I could get coverage that could—or something, that there could be a back-and-forth, if they work for me or work for somebody else, because the employees are so transferable, and it is a need that is required by business now. Some large employers in the area use them a lot.

That is why I talk about it under a payroll system that possibly could be taken care of that way. It costs about 50 cents an hour to cover somebody for medical.

The people who I am able to cover, that work for me over a year, are covered, if they continue to work, and it is about 50 cents an hour no matter what rate pay they have. So, percentage-wise, it changes depending on the employee.

The portability, I think, is really important, because people are now working temporary. Major corporations are laying people off. Decisions are being made about employment that way.

So, I think portability of insurance is extremely important, and I think that it would be simpler to have it where they could be covered that way. I see us growing as an industry, too.

Mr. KOPETSKI. Before I go back to Gene here, the nature of your business is that you want workers that maybe they want to work 1 day a week or 3 days a week.

Ms. BROOKS. They work as often—I have some employees that have been working at one location for 8 years, and I have employees that work as little as a day, and it varies, and we want employees that are as flexible as possible, of course.

It is in our best interest to have that, but some employees like to work that way, and often, it is a way for them to get their foot in the door, to get permanent jobs elsewhere.

Mr. KOPETSKI. Do you want to hire more people as permanent employees for yourself?

Ms. BROOKS. At this point in time, growth would depend on that. If I could grow more, I would maybe open another office and have a couple of other more permanent employees. It does not take a lot of permanent employees to handle a temporary service office.

Mr. KOPETSKI. How significant in that decision, of whether you are going to expand or not, hire more people, is the cost of health care?

Ms. BROOKS. Well, recently, because of the escalation of cost—when I took the coverage out, it was $68 a month. It is now $126 a month, and that has escalated over a 5-year period.

Right now, I cover my employees and do not cover their dependents. Most of them do not take on the dependent care. They choose not to because they feel they cannot afford it. They are making $7 and $8 an hour. So, some choose to take it. Most choose not to cover their dependents. Some are covered by their spouses.

At this point in time, I almost cannot cover them, because I have a person with cancer, and I cannot do anything now. I am kind of stuck.

Mr. KOPETSKI. I think the portability issue is very important, as well as elimination of preexisting conditions, and I hope we can get there.

Ms. Selby, what are the independent contractors doing? What are you doing, personally? Do you go out and purchase your own insurance?

Ms. SELBY. Out of seven employees, we have two people who have insurance, and the others do not have any insurance.

Mr. KOPETSKI. Whether through a spouse or——

Ms. SELBY. None.

Mr. KOPETSKI. None.

Ms. SELBY. Yes.

Mr. KOPETSKI. How old are they?

Ms. SELBY. One is in the late 30's, but the others are younger. One is 51 or 52.

Mr. KOPETSKI. What do they say? I am not going to get sick?

Ms. SELBY. No. They say they cannot afford it, and they will pay the bills when they come. I mean they just pay their health bills when they get sick.

Mr. KOPETSKI. Are these college graduates?

Ms. SELBY. Yes.

Mr. KOPETSKI. These are college graduates.

Ms. SELBY. Yes.

Mr. KOPETSKI. Do they make over $100,000 a year?

Ms. SELBY. No.

Mr. KOPETSKI. Do they know the price of an appendicitis operation or how many thousands of dollars it costs a day in a hospital?

Ms. SELBY. The other person who does have insurance, she has a $2,500 deductible.

Mr. KOPETSKI. Did they go to Oregon colleges?

Gene, you were about to say something.

Mr. SAYLER. Yes, Congressman. You asked a specific question, the cost as a percentage of payroll. I happened to research that exact question, and for us, it runs—for the last 3 years, it has run 4.9 to 5.0 percent, right around $90,000 a year, which is tolerable, and even if it went to a 7-percent payroll tax, I suppose we could—I would hate to do it, but we could stand that 2 percent.

The thing we could not stand, though, is if you went to a flat rate per employee per month and that worked out to $1,800 a year. That would drive our cost for 160 employees up from $90,000 a year to $288,000 a year, and I would tell you that, throughout all small business, there would be great impetus to eliminate part-time employees or hire them less than 15 hours a week, one of the two.

There would be great impetus, in my company and many others, to shrink that 160 employees down to maybe 120 and make them work full-time, because your cost per employee would be substantially less, and I do not think you guys would want that intention. There are a lot of people who like working part-time.

Mr. KOPETSKI. OK. That is good information. Thank you.

Thank you, Mr. Chairman.

Chairman WYDEN. Well said, and you are right, Mr. Sayler, there are not a lot of rallies outside our offices for eliminating any jobs.

We need more jobs, and the idea is to look at a health system that is going to allow us to be more productive rather than less, and that is what we have got to wrestle with.

Let me start, if I could, Ms. Selby. You indicated that you wanted a single-payer system.

Now, my understanding is that the single-payer system and the single-payer legislation that has been introduced calls for some pretty significant taxes, payroll taxes, and other kinds of taxes.

Does that change your mind at all, because I think, for a lot of businesses, those would be greater than some of the other ideas that are being kicked around.

Ms. SELBY. What I am interested in is reducing cost, and I see that, if you take out some of the middle men and simplify the forms—I managed my parents' finances and my in-laws' finances before they passed away, and I could not believe the complexity of the health forms, of the bills that they would get, a three-page bill, and then, at the bottom, in small print, it says do not pay, your insurance company has been billed.

Well, senior citizens are very conscientious, and they pay these things, and then there is a double payment, and then you have got to wait, and I mean it is very complicated. It is complicated to me, let alone to people who, you know, their faculties might be fading.

So, I see that as a simple, direct method that would cut out a lot of the administrative costs and would be a way that you could direct medical resources in a more cost-effective way and a more—well, a more effective way, so that people who need the services get it in small communities in Oregon or more general practitioners or whatever.

It would be a dramatical, radical reform of the system, which I think is what is needed if we are going to get a handle on it, and so, I would support that and cut out the middle insurance company.

Chairman WYDEN. Well, I strongly support what you are talking about in terms of reducing these unnecessary middle-person services.

I issued a General Accounting Office report last week that showed that two out of three of the Medicare appeals are reversed, they actually have a change in decision, because when an appeal is denied for a medical necessity, they do not have experienced people reviewing the claims, and two out of three of them are actually reversed.

So, there is no question that the administrative systems are significantly out of control, that we are wasting money on paper, and I think you are going to get your desire in terms of a uniform billing system.

I would only caution, again, as we debate these issues—and that is what we starting to do—that the single-payer plan, under the McDermott single-payer plan, the employer portion of the health insurance tax would be increased from the current $1.45 of wages to 7.9 percent.

So, again, we are going to have to think through all the implications, and that is because it is impossible to collapse what you have now and go to a single-payer system without some additional revenue.

So, I think you are going to get a lot of support for what you are talking about in terms of reducing middle men and administrative costs and clerks and the like, but as we debate this whole thing, I thought you would be interested to know that the single-payer proposal that is in the Congress does call for some pretty significant tax hikes and some things that I think we are going to want to talk about.

Ms. SELBY. I thought there was more than one proposal to be put forth at a later date when the health plan comes out, and as I said in my remarks, I am in favor of a cost-effective way.

Chairman WYDEN. We, as well, and I am speaking of the single-payer plan in the McDermott bill, which is the one with more than 80 sponsors.

Ms. SELBY. I am not interested in paying 7.9 percent. Thank you very much.

Chairman WYDEN. I got the feeling that there was no one at the table who was willing to be throwing up big cheers for taxes.

I think Mr. Kopetski is on a very, very tight schedule. I am going to have some additional questions, but I want to recognize him, if he has anything else he wants to conclude with.

Mr. KOPETSKI. I appreciate this morning's hearing. All the witnesses were very helpful to us.

This is the opening round of what is going to be one of many discussions and debates, and I think the temperature on all of them is going to rise as the President unveils his plan, and what I do encourage is, as people read about it, that they contact our offices to get the facts—i.e., what is really in the plan—and then to sit down and think through it and see what is workable and, constructively, what is not, because as I say, this is critical to us as a Nation for lots of reasons, and I am going to be seeing you folks again, I know, as soon as the President comes out with his plan, but Mr. Chair-

man, thank you very much for inviting me and allowing me to participate.

Chairman WYDEN. I thank my friend, and hopefully, the Energy and Commerce Committee will get the easier portions, and we will let you guys finance it and deal with all these tax things that can be so tricky.

Mr. KOPETSKI. I think this is the one time that, in terms of jurisdictional fights, it is, well, you get to do it.

Chairman WYDEN. That is right.

Mr. KOPETSKI. Thank you.

Chairman WYDEN. Let me move on to Ms. Brooks. You had one of the more interesting ideas, or at least one that I do not get a whole lot, where you propose that, possibly, there ought to be a sales tax dedicated to health, and again, I do not find a lot of people coming up and saying, Ron, you know, sales tax, either.

What is your feeling in terms of that? Why is that something that, in this world of hard choices and not ideal options, why is that of appeal to you?

Ms. BROOKS. Well, I think it would take some of the burden off businesses, because the price would not have to as high as you talked about, the 7.9 percent, possibly, and if employees and employers are sharing it 50 percent and bringing in cost containment, something tells me you do not need to go to 7.9 percent anyway. Medicare is at 1.45 percent and is not working at all because of the costs in that.

So, my thoughts are cost containment, and the reason I felt another tax law of some sort that is universal—it would cover everybody, even those people who are in the underground employment area, people who do not pay taxes at all, people who work doing odd jobs, people who work as day care providers that do not pay, people who just avoid taxes for whatever reason.

They would, with universal care, be covered. However, they would then have to at least pay some of it, and the burden would be shifted—it would be to everybody. So, that is where my thoughts come in, is that everybody would have to pay for that.

Chairman WYDEN. Let me ask about this tax and revenue issue that we really have not talked about today in a little bit of a different way.

We are going to spend close to $900 billion this year on health care in the United States. We have got a little over 250 million people in the United States.

So, you divide 250 million into $900 billion and every man, woman, and child could get $3,000—more than $3,000 in order to get a health package, and it is kind of like the Federal Government could send everybody a check for $3,000 and say, here, Ms. Selby, best wishes, $3,000, get a health package.

So, I really go into this debate saying that the first job that the Federal Government has got to do is to show people like you that the money in the system now is being spent more effectively before we go out and suddenly start hauling revenue from here and there and elsewhere. We have got to show you that the money that is being spent in the system now is being spent effectively.

Now, the one source of new revenue that it seems to me there is an appealing case for now that I am surprised nobody has men-

tioned today is the cigarette tax, and there is a fair amount of evidence that the President is going to include that in his proposal, possibly even a buck a pack, which raises several billions of dollars a year.

Let us just go down the line on whether you all, in terms of your businesses, what you do, would see that as one acceptable way to generate revenue in order to get this going. Ms. Selby?

Ms. SELBY. Well, the best taxes are a tax that somebody else pays. So, this is that idea, that people who smoke would have to pay.

I was kind of reserving that for Oregon and hoping that paid for the Oregon health plan.

Chairman WYDEN. We get it first, right?

Ms. SELBY. Right.

Chairman WYDEN. What was the Oregon health plan? Ten cents a pack?

Ms. SELBY. I do not know, but that was one of the ideas, and the health care providers also pay, but it is a saleable tax, because—I mean you can sell it to the public, because it is somebody else paying, but there are dwindling numbers of cigarette smokers in the country, and that should continue, and what are the long-term projections for that tax? I have no idea.

Chairman WYDEN. It is also related to behavior. If that was one thing I heard this morning—Mike Kopetski and I heard it again and again—bring back the individual into this process.

Individuals count, there are no free goods in society, and we do know that the individual who smokes is likely to need health care services, and we spend billions of dollars each year in Medicare alone, for example, in terms of paying for those costs.

Any other the others of you on the cigarette tax?

Ms. BROOKS. A cigarette tax would bring in income, but we should be trying to stop people from smoking. So, if you are getting a dollar a pack and you are trying to get people to quit, then your taxes are going to go down to pay for it.

So, I think you have to be really careful on any kind of tax that comes in for cigarette smoking. People should not smoke, you want to encourage them to quit, but you are going to want the income from the tax.

So, I think you have to be really careful and do some other things, like stop advertising and stop paying people to give away free cigarettes at concerts to encourage young people to smoke, and things like that will need to be looked at, as well.

Chairman WYDEN. Mr. Sayler?

Mr. SAYLER. I am opposed to excise taxes going for general purpose money, and I guess I would agree with everything the lady said here, and it is an unstable fund. If you raise it a dollar a pack, it is going to go down. It is probably not going to bring in the anticipated or needed revenue.

I would also say that I recently read a piece that says cigarette smokers are already paying for all their sins in terms of current taxes they pay more than cover their additional burden on the societal system, I guess. So, I suppose there are people who would disagree with that.

Chairman WYDEN. Send me that article.

Mr. Laney, do you want to add anything to that?

Mr. LANEY. No, other than to say that I agree, it seems—as a tax, it seems awfully fleeting, perhaps not as stable as it should be.

Chairman WYDEN. Evidence shows you cannot get more than a dollar a pack without a significant reduction in use, but you can probably get a dollar a pack.

On the cost containment issue, I asked Mr. Gilliam what other cost containment tools he was interested in. Purchasing cooperatives are one.

Mr. Sayler really takes what is the gutsiest position out there. His organization wants to limit deductions for employers and also tax-favored treatment for employees.

Mr. SAYLER. Of very rich benefit plans.

Chairman WYDEN. Usually an idea that can start a riot just about anywhere it is offered.

What other ideas would seem, from your standpoint, to be helpful on the cost containment side? We will start with you, Mr. Laney.

Mr. LANEY. Cost containment, in my mind, is a difficult issue in many ways, primarily because you hear people say, gosh, it costs $3,000 a day or $10,000 a day or whatever to receive this care, and 10 years ago it cost $1,700, and it is always just a very small portion of the current cost.

I think the danger in that is, number one, you have to ask yourself what value do you receive for that money, and it is not all being eaten up by increased doctors' appetites for Mercedes cars and et cetera.

There is a whole bunch of technology that is in the hospital today that was not even 5 or 10 years ago. Many times, doctor's office technology exceeds hospital technology in the short term past.

So, you have to ask yourself, from an economics viewpoint, what is the benefit of that? It seems to me that is a lot of durable goods and it is a lot of taxes that have been paid to get that technology into the hospital.

So, I think you need to separate the perception that, gosh, we can just charge whatever we want, so why don't we, and we will have big boats and we will have corporate jets and all that. I do not think that is the reality.

I think step one is to decide, from a cost containment standpoint, what is a real cost and what could be eliminated, and I do not think that has been done. So, it is difficult to tell about cost containments right now.

Chairman WYDEN. You are asking about the other area I wanted to discuss with you, because we have not mentioned it, and that is that the congressional Budget Office recently said that close to half of the rate of growth in health care is due to technology, close to half of it, and what I pick up from the buyers, the health maintenance organization and insurance company, people who are running their own plans, self-insured, is that people are constantly trying to peddle new medical technology to them, and they do not have good information to show how that technology somebody is trying to sell them would do something for them that they cannot already get.

I mean if you are using a catheter, for example, at a hospital and somebody tries to sell you another catheter, you are interested in two things in that new catheter.

One, is it diagnostically superior to the other catheter, and two, you want to know, if it is not diagnostically superior, is it cheaper than the one that you are now using, and as far as I can tell, that information is not available up front to buyers, and so, I have been working on a proposal with the medical technology companies to try to give an incentive to companies to give that information out to people like yourselves and your organizations, I mean have them get some kind of extra incentive, possibly going to the head of the line for approval for their devices at the Food and Drug Administration, that sort of thing, but I gather that you, Mr. Laney, think that this technology question is a very serious, essentially untapped area with respect to health reform.

Mr. LANEY. I think, at our level—I do not think that most people who are walking down the street have the type of expertise that you have in this area.

So, I think, once we go the next step—when, through whatever means, we are able to bring the message of just what is medical technology to the common person that utilizes the technology, then there is a benefit to be had, but my point was, more simply, right now, we have not done that, and I think the perception is that we are building better mousetraps for no apparent reason, and many times, that is obviously not true.

Chairman WYDEN. In the 1980's, a good chunk of the drugs that were developed were me-too's, and a good chunk of the medical devices were, as well, because the system did not reward people who were, in effect, bringing kind of value-added components to it.

What is your sense on the technology issue, Mr. Sayler? You were in the legislature. You are a business person, working with various plans, and you have watched this technology issue and even the turf battles about who gets it, unfold in Portland. What do you think ought to be done?

Mr. SAYLER. My sense is, Congressman Wyden, that competition in the traditional sense, the kind we learn in Economics 101, does not apply to the health care industry.

I was a little nervous when the first group of witnesses, Joe Gilliam and them, kept talking about competition.

Competition in health care, particularly in these large hospitals, seems to revolve more around who has the latest technology, and if, then, one of them has it, the other one has to have it to compete, but price is not a part of the competition.

I do not know, other than that. It is just my sense that——

Chairman WYDEN. It is amazing to hear someone like yourself, who is a business person, who will, by anybody's calculus, call themselves, pretty conservative, saying medical competition does not essential work in health care.

Mr. SAYLER. It does not.

Chairman WYDEN. My own sense is it does in some parts and it does not in others. The question is going to be how do we find the right mix. I mean we have a uniquely American system.

Ms. Selby makes a very compelling point, that she is up to her eyeballs right now in terms of trying to run a business, and if

something is done that is burdensome or not cost-effective, it is going to push her over the edge, and she is not going to run a business.

So, we have got to find a system that is not one-size-fits-all, and it will probably take something that works for Selby, something else that works for different size employers, something else that may work in Mississippi, something else that works in the Bronx, and this is going to require some very careful work.

Do you want to add anything else?

Mr. SAYLER. Well, I just think, ultimately, some decision has to rest with the individual, and there needs to be some incentive with the individual not to overuse the system.

I do not know. Based on a person's, do they be responsible for the first so many dollars of primary care, so that, if they wake up with a bad cold some morning, they think twice before they run to the doctor, because it is going to cost me $50 to go visit my doctor? I do not know.

Ms. BROOKS. One problem with that—and I agree with you on not overusing, but one of the things that could happen is well-baby care and immunization, some up-front things that are preventive needs can make sense, and you need to encourage people to do that, maybe.

So, there is kind of a double thing there. Do not overuse, but use it wisely, and maybe some training needs to be involved in some of that.

Chairman WYDEN. The irony about the immunization issue is that much of what needs to be done is not a question of spending money. In the State of Oregon, no kid is going to be denied a vaccine because of cost. Every single kid who needs it can get it free.

The problem is we have not reached a lot of the parents, and they have child care problems, transportation problems, and some of them may not be comfortable with the language, and so, there are issues here that also relate to the social aspects of delivering health care and do not have anything to do with taxes and whether it is 1.45 or 3.4 percent or anything else.

Let me just leave you with this: Every single group in our society, whether they are trial lawyers or insurers or anybody else, is going to, I think, have concerns about what Congress is working on, and as far as I can tell, this will probably be as vigorous and fiercely fought debate as we have had in our country for a long, long time.

I think it is going to make the debate about the budget look like small potatoes, but I can tell you, I think, in our delegation, we understand how important it is to do this small business issue well and carefully, and I chair this small business subcommittee.

Virtually every one of you have come today because you want to be at the table. Well, that is what we are doing here. We are sitting at the tables, hashing it through. The President has not even come forward with his proposal yet, and we are already trying to think through the implications.

So, our door is open, we are going to need your ideas, we are going to need your input, and to the extent that you can give us these accounts from the front lines, what it really means for your business, the part-time workers that Gene Sayler is talking about,

the people who you mentioned, Ms. Selby, who may or may not be getting any coverage or getting coverage with a spouse, these are the issues that have got to be dealt with, because this is what it is going to take to do the job well.

There are a lot of parts of this plan, I think, that we can get agreement on, fairly quickly. We mentioned—and all of you have today—the purchasing cooperatives. No question, if you are a itty-bitty logging company, you do not have the bargaining power of Weyerhauser.

So, we are going to try and figure out how, through these purchasing cooperatives, to give you some real bargaining muscle like a big timber company would have, but there are literally dozens of other issues that we talked about today, the revenue questions and what ought to be asked of each group in our society in terms of getting this done that are far from fleshed out.

So, you are great to come and give us 3 hours of your time and your input.

I would note that that probably costs you money, too, Ms. Selby, and going to congressional hearings every day may not be the most productive use of your resources, but we do want your input and that of your colleagues, and give us your input, give us your ideas, and unless you have anything further, we will excuse you at this time.

Thank you.

[Whereupon, at 1 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

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APPENDIX

OPENING STATEMENT
CHAIRMAN RON WYDEN
COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES AND ENERGY
FIELD HEARING
SEPTEMBER 1, 1993

Today's hearing is being convened because developing workable solutions to the health care crisis for small business is the key to enacting effective health care reform in this Congress.

This issue is a top economic development concern for Oregon because our state has one of the largest concentrations of small businesses in the country. About half of our state's businesses employ under 50 people, and small business is the muscle and sinew of almost every Main St. in Oregon. For thousands of small Oregon businesses, health costs are their fastest rising expense, and about 185,000 of Oregon's 479,000 uninsured citizens are small business employees or their dependents.

President Clinton has not yet announced his health care reform proposal, but press reports that the Presidents plan will contain mandates that are costly, inflexible and burdensome have been frightening to many Oregon business owners.

Let me assure Oregon businesses right now: so called "health reforms" that cripple small business will mean Oregonians have fewer jobs and reduced prospects for health coverage, and I'll oppose them.

Health reform that produces real cost containment for small business, protects small business employees from unfairly being denied coverage by insurers and preserves choice of providers for those employees will make Oregon more productive ---- and I'll pull out all the stops to see it enacted.

Responsible health reform will require that major economic forces in our society - such as insurance companies, medical providers, trial lawyers and, yes, small businesses -- be willing to share responsibility and accept changes in the status quo.

Insurance companies won't be able to cherry pick any longer, and just take healthy people. Medical providers will face changes in reimbursement practices, particularly for procedures that were once difficult, but are now more routine. Trial lawyers will be required to accept changes that can reduce medical malpractice costs and the expense of defensive medicine. I plan today to ask each of the small business groups their opinion of what small business can fairly be asked to put on the table.

I'm convinced that working together we can deal with this critical issue. Already, there is strong bi-partisan support for a health plan that contains key features that many small businesses find appealing: cost containment through the establishment of purchasing cooperatives that give small businesses the same kind of bargaining muscle big firms have, establishment of a basic benefit package that emphasizes health care prevention, expansion of tax deductions for the self-employed, Medicaid reform, special consideration for the smallest of businesses, and phasing-in the overall plan over a number of years. There are a number of other ideas that I intend to explore today.

What's clear, however, is the cost of doing health care business as usual is prohibitively high. Medical costs are gobbling up everything in sight, and like acid are eating away at the survivability and profitability of small businesses across our state.

Health care reform is finally at the top of the Congressional agenda, and we are here to get the views of Oregon's small businesses so we can help get the job done right.

News from
Congressman Mike Kopetski
5th District -- Oregon

Opening Statement of
The Honorable Mike Kopetski
Field Hearing of the Small Business Committee's
Subcommittee on Regulation, Business Opportunities, and Energy
September 1, 1993 — Portland, Oregon

Mr. Chairman, I am pleased to be invited to participate in today's hearing on small business and health care reform. This is going to be one of the thorniest aspects of health care reform. Small businesses are a crucial part of our economy, and their health is vital to a strong economic recovery.

As we all know, our current health care system is employment based, and has been so since shortly after the end of the second World War. Approximately two-thirds of those with health care insurance under the age of 65 have insurance through an employment-based group, either because their own employer offered it or because they were insured as a dependent of a worker whose employer offered group coverage. It is clear that any health care reform undertaken---whether in the direction of mandating employer coverage or contributions or in the direction of establishing a government-run, single-payer health care system---will affect both the businesses that are paying for coverage now and those that aren't.

The President is expected to unveil his health care reform proposal by the end of the month, and reports are that the proposal will mandate that employers contribute to the cost of covering their workers. Indications are that employers will be required to contribute a portion of the market premium for their employees' health plan, but that the contribution will be capped at a relatively low percentage for small firms, and at a higher percentage for larger firms. Under the President's proposal the requirement will be phased in, and assistance will be given to businesses with very low-wage workers and for very small businesses.

Oregon is a particularly apt place to hold this hearing. Oregon has both a higher than average percentage of its population without health care insurance (over 16 percent of Oregonians under age 65--almost half a million Oregonians--are without health insurance,

(over)

compared with a national average of roughly 14 percent), and a higher than average concentration of small businesses. Oregon is a small business state; small firms with 50 or fewer employees represent 96 percent of Oregon's businesses and employ 47 percent of its private work force. Fifty five percent of Oregon businesses employ between one and four workers, and Oregon has a higher than average percentage of agricultural workers, one of the sectors of the economy with a low rate of worker health insurance. We must be very careful in working on health care reform to ensure the health of small businesses and family farms in Oregon while improving access to quality health care.

We can't just enact mandates without addressing the reasons why many small businesses aren't providing coverage. Small businesses are at a severe disadvantage in providing health care compared to large employers. Small businesses are not able to spread risks widely, are in a weaker bargaining position with insurance companies than larger employers, and are faced with much higher administrative costs. Administrative costs consume 40 cents of every dollar paid in total health premiums for businesses with fewer than five employees, compared to administrative costs of around five cents per dollar for large companies.

We must also keep in mind that small businesses, like all businesses, want to take care of their employees. Despite the steep costs involved, according to the Department of Labor roughly 62% of American businesses with fewer than 100 employees provide health care coverage to their employees. However, unless we act soon this percentage will drop significantly. A recent survey found that some 30% of small firms are considering dropping health insurance benefits because of the cost, and thirteen percent of respondents to the same survey indicated that they had dropped coverage within the preceding three years. Health care reform including employer mandates will simply not work unless we get a handle on the reasons that our current employer-based system isn't working now.

I am looking forward to today's hearing, and to the release of the President's proposal. Health care reform is going to be successful only if everybody gets into the act. We must have a full and open debate on the issues involved, and I am pleased to join my colleague Rep. Wyden in starting this process.

A Presentation
To The Subcommittee on Small Business, Regulations and Business Opportunities
Field Hearings Held at the Metro Building in Portland, Oregon
September 1, 1993

By Chad Cheriel, Ph.D.
Director, Office of Health Policy
Department of Human Resources, Oregon

I wish to thank the Honorable Representative Ron Wyden for offering me the opportunity to present current information about health insurance and lack of insurance among the population in Oregon. The Office of Health Policy just released a report titled "Health Insurance Coverage in Oregon: Estimates for 1990 to 1992." The report was produced with financial support from the Robert Wood Johnson Foundation as part of the foundation's initiatives for advancing universal access to health care.

In spite of the billions of dollars we spend on health care in this country, only limited information about the demographics, benefits offered and coverage patterns of population with and without health insurance is available to the public. The data we have compiled represent the best information available anywhere in the state about health insurance and lack of insurance. These estimates will be refined with data from business and household surveys that are currently under way in Oregon, again with the financial support of the RWJ Foundation.

Before reviewing the key statistics and findings from our report, let me briefly mention the concerns that are driving the consumers, purchasers and providers to search for new solutions to problems of health care. Increasing health care costs and declining insurance coverage have become a burden to consumers, government and businesses in this country. Many observers have noted that we no longer can sustain the current pattern of growth in health expenditures relative to overall economic growth.

In brief, our analysis of the Oregon data for 1990 and 1992 shows that:

- The number of uninsured in Oregon is growing at an alarming rate (a 10% increase over a two-year period). This rate of growth far outstrips the rate of growth for the population in general (about 3% over the same two-year period) and will mean an additional 20,000 to 25,000 uninsured Oregonians each year if it continues.

- Oregon looks slightly worse than the nation in terms of percent of population uninsured.

- Health insurance is eroding dramatically for middle-income families (with

incomes from $15,000 to $45,000).

- 72 percent of uninsured adults work, and 69 percent of uninsured adults are above FPL.

- Women aged 40-49 and men aged 50-64 lost coverage significantly from 1990 to 1992.

- The situation is improving for low-income children (although not for children in middle-income families, who are losing coverage), but getting significantly worse for adults as a whole; improvement for low-income children is attributed to additional Medicaid enrollment under the PLM program rather than increased coverage through parents' employment.

- Most uninsured adults are over 30 years of age.

A more detailed look of the Oregon data shows:

A. Number of uninsured: Oregon has a slightly higher percentage of its population in the uninsured ranks: 479,000 uninsured represents 16 percent of the state's population. The uninsured rate in Oregon appears to be growing faster than the national rate.

B. Employment status

1. Oregonians working full time showed a significant increase in numbers of uninsured from 1990 to 1992, from 135,000 to 171,000, and from 12.2 percent to 14.8 percent.

2. Oregonians working part time (defined as fewer than 35 hours per week) also showed a significant increase in the uninsured over the same two-year period, from 68,000 to 86,000, and from 22.8 percent to 27.5 percent.

3. Oregonians not working showed a slight increase in numbers of uninsured, from 83,000 to 97,000, and from 25.6 percent to 27.9 percent.

C. Industry type

1. In some industries, health coverage for full-time employees remains widespread. In government, about 83 percent of those working full time are covered through their own employment; in education, the figure is about 82

percent, and in transportation/communication, about 80 percent.

2. In many industries, health coverage for full-time employees is much less common. In agriculture/forestry, approximately 36 percent of full-time workers are covered through their own employment, and in construction the figure is about 44 percent.

D. Characteristics of the uninsured in Oregon

1. Age - 354,000 are adults (aged 18 through 64), and 125,000 are children. Fewer than half (about 42%) of uninsured adults are below age 30, and about a third (about 34%) are 40 or older.

2. Gender - In both absolute numbers and percentages, men and women show very similar uninsurance profiles: among men, there are 178,000 uninsured, which is about 19.8% of that population; among women, 176,000, which is about 19.5% of that population.

   Trends indicate that uninsurance is worsening faster for men than for women. Over the two-year period, 1990 to 1992, uninsurance among men went from 17.9% to 19.8%, or 1.9 percentage points; for women, the increase was from 18.4% to 19.5%, or 1.1 percentage points.

3. Income - The only income category showing an improvement over the two-year period observed was $45,000 and up.

   Uninsurance among those in the lowest income category (under $5,000 per year) remains fairly constant.

   There is dramatic deterioration of health coverage for those in the lower and middle income categories.

   a. For those with incomes of $5,000 to $44,999, the number of uninsured increased from 222,000 to 301,000 from 1990 to 1992. This is an increase of 36% in just two years.

   b. For those with incomes of $15,000 to $44,999, the deterioration is even more striking; the number of uninsured increased from 99,000 to 149,000 from 1990 to 1992, an increase of just over 50 percent.

   c. Trends for these income categories show that without effective health reform, more than 60 percent of adult Oregonians in the income category $5,000 to $14,999 will be uninsured.

4. Marital status/Family composition - Families with children account for about 43 percent of Oregon's uninsured. Both being married and having children increase the likelihood that an adult Oregonian will have health coverage.

5. Geographic location - The insurance coverage situation is getting better in the Willamette Valley, and much better in the coastal counties; in both these regions, the number of uninsured and the percentage of uninsured decreased from 1990 to 1992. In the coastal counties, the number of uninsured went from 39,000 to 29,000, and the percentage of uninsured went from 18.8% to 13.4%. In all other regions of the state, the situation is getting worse. One theory regarding this coastal anomaly is that the difference between the number of insured retirees moving into the area and the number of uninsured leaving can explain a good part of this phenomenon.

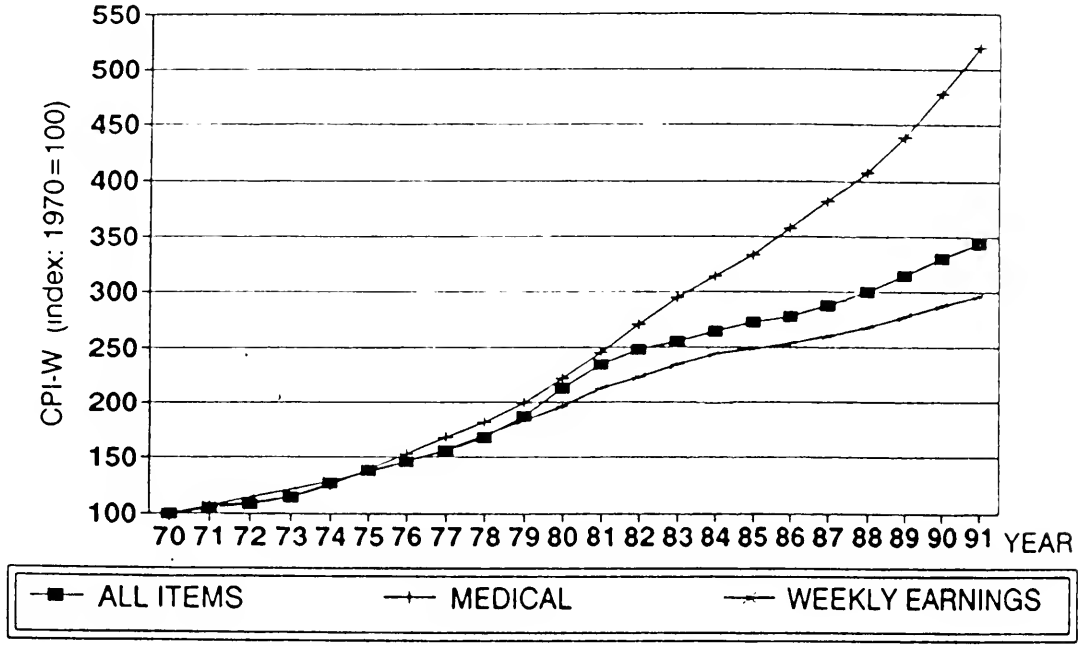
   Things are getting worse in the Greater Portland Area counties, southern counties, central counties, and eastern/southeastern counties. The percentage of uninsured increased by about 2 points from 1990 to 1992 in each of these four regions. In the southern counties, the 1992 figure is 23%; if this trend continues, we can expect nearly a 30% uninsurance rate in this region by 1998.

E. Conclusions

The rate growth in the uninsured numbers in the state may signify a recipe for disaster for the state's economy and the health care system. Developments taking place in the economy such as ongoing disruptions of Oregon's economy (the timber industry in particular, increasingly rapid in-migration and overall growth, more and more resources going to health care for a smaller and smaller proportion of the population, and the absence of a fair and equitable health care financing system will worsen the problem.

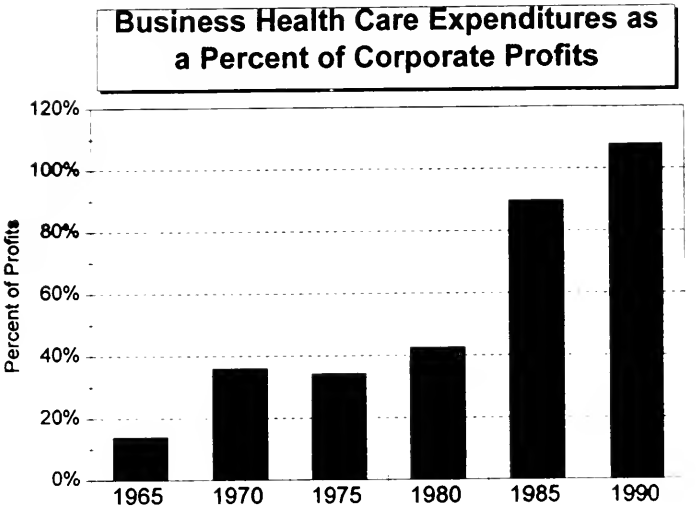
What this means, of course, is that effective health reform is needed soon, and although such reform may seem expensive, it will be even more expensive not to effect reform, both in terms of dollars and in terms of deteriorating health.

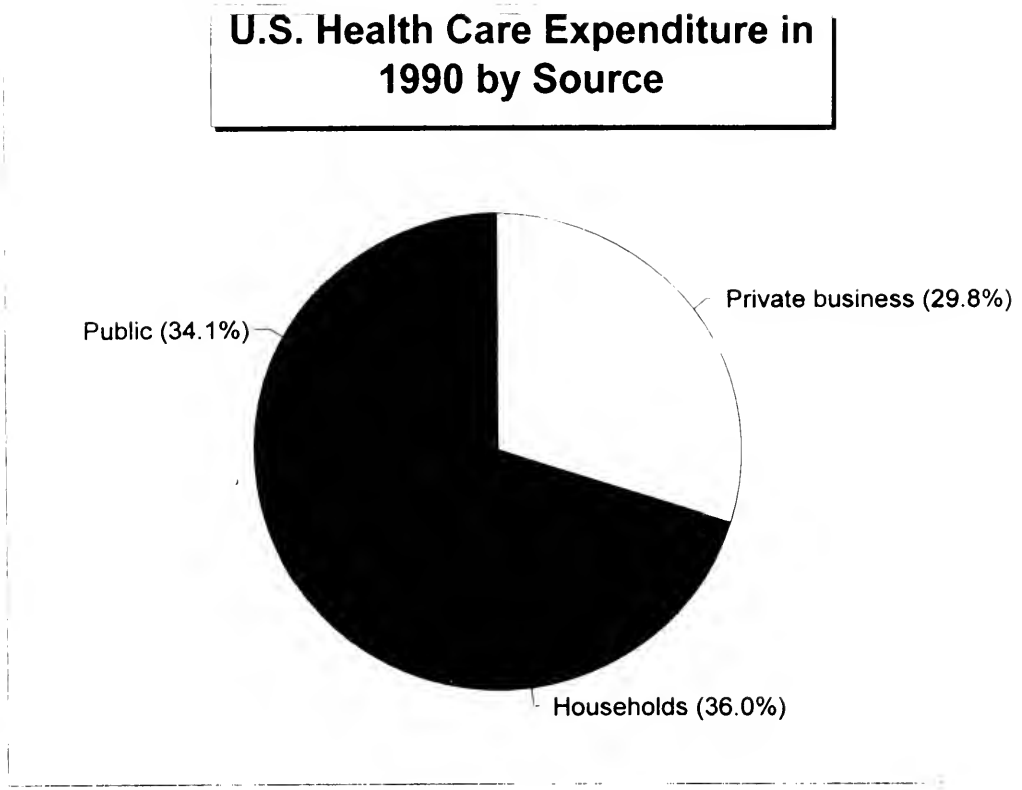
INDEX OF INCREASES SINCE 1970



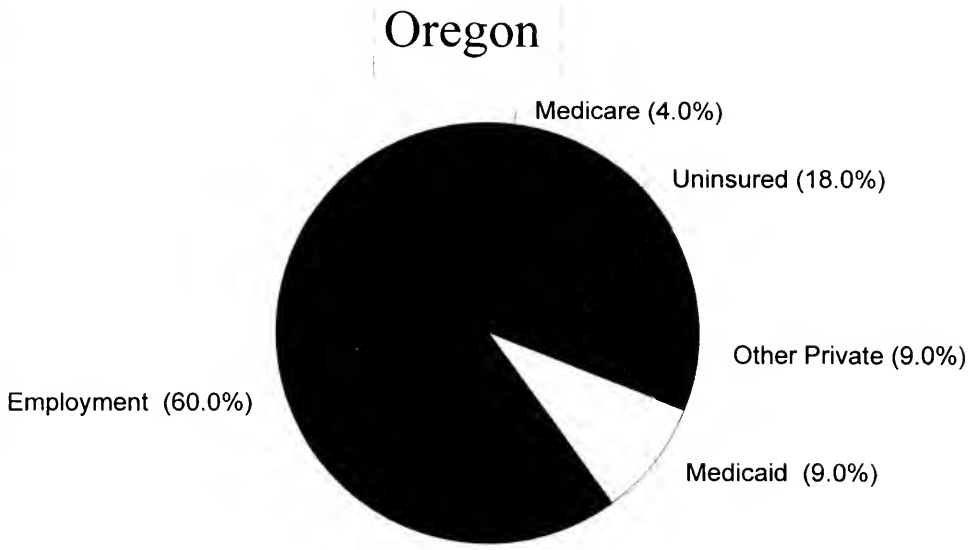
SOURCE: Bureau of Labor Statistics, through July,1991

*average weekly earnings are for private nonfarm production/nonsupervisory employees


Business Health Care Expenditures as a Percent of Corporate Profits
Percent of Profits
120%
100%
80%
60%
40%
20%
0%
1965
1970
1975
1980
1985
1990

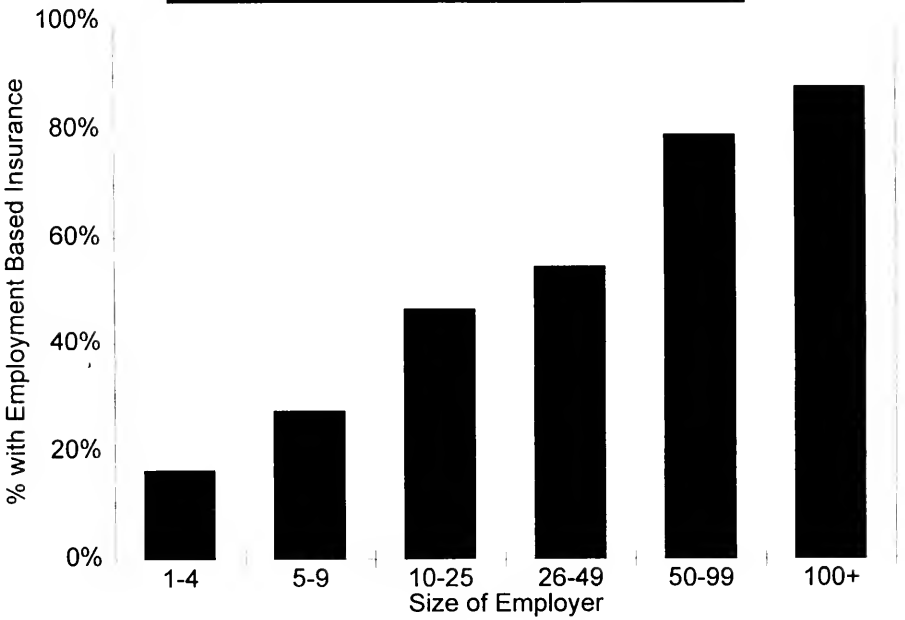

U.S. Health Care Expenditure in 1990 by Source
Private business (29.8%)
Public (34.1%)
Households (36.0%)

Sources of Health Insurance in 1992



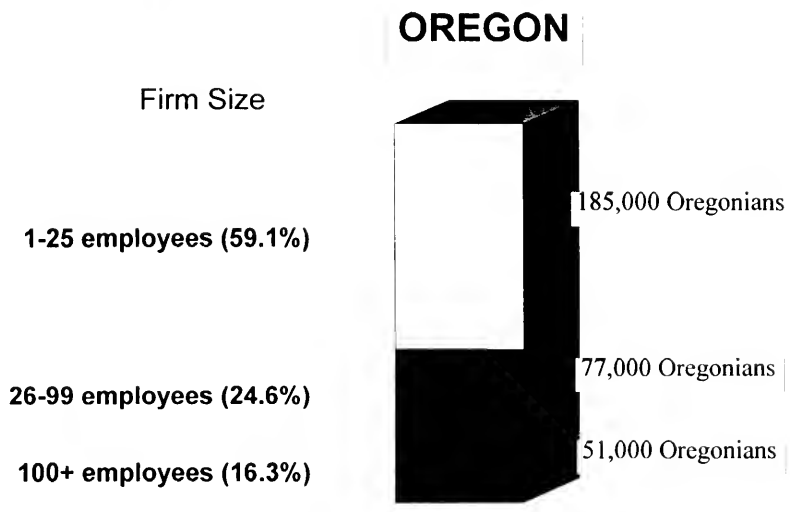
Sources: Office of Health Policy

Workers with Employment Based Health Insurance, 1992 Oregon Est.



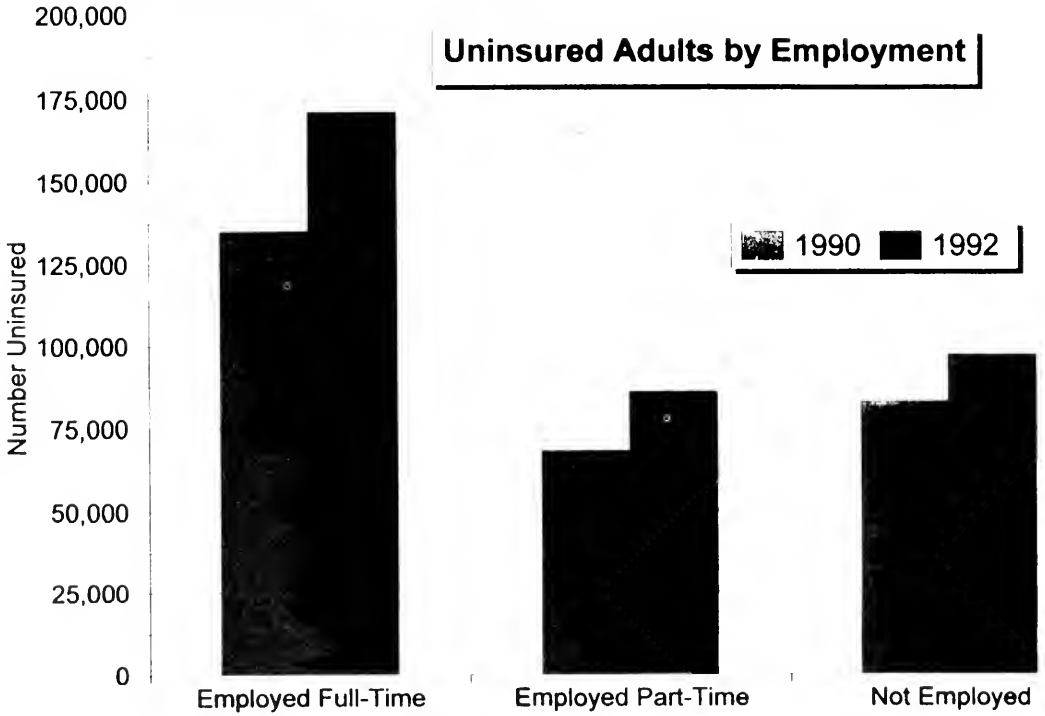
Oregon: Office of Health Policy
note: does not distinguish between own or spouses employer

Uninsured Working Adults and Dependents by Size of Employer in 1992

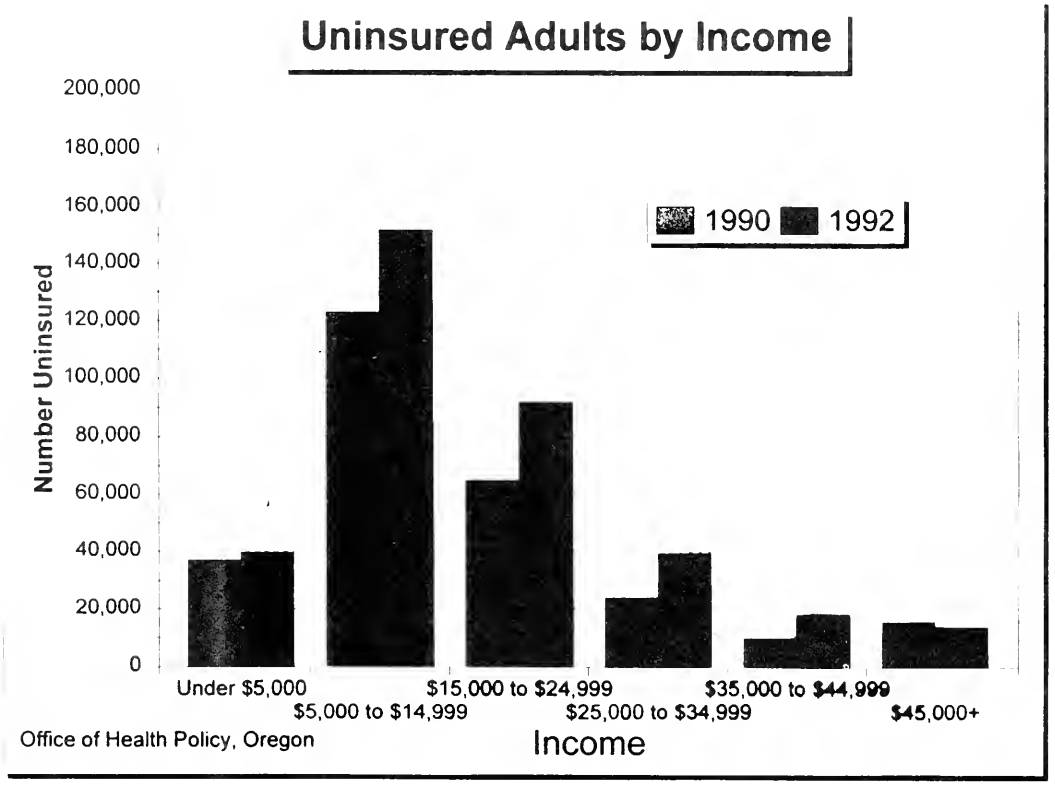


Office of Health Policy, Oregon

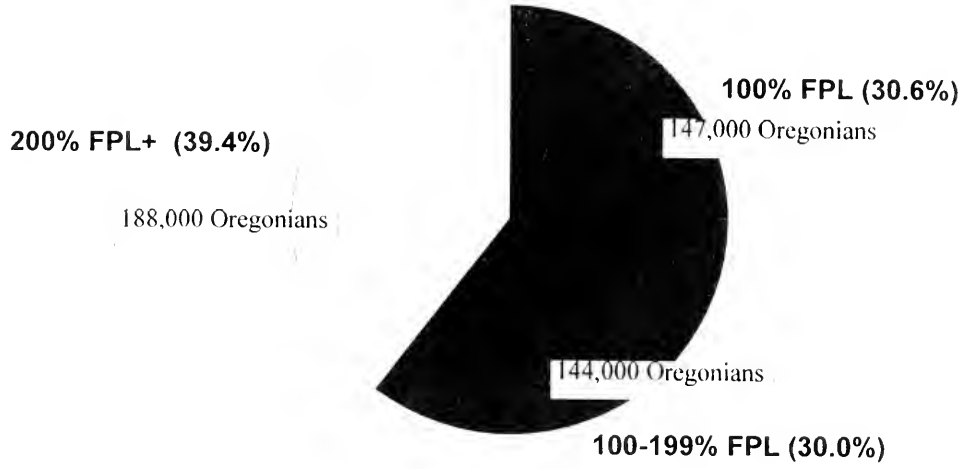
Employment Provided Insurance
for Full-time Workers in Oregon, 1992
Percent in each Industry
100%
80%
60%
40%
20%
0%
Ag/Forestry
Construct.
Manuf.
Transp.
Trade -W
Trade -R
Finance/Ins
Bus. Service
Health/Soc.S
Govt.
Education
Serv.(other)
Own Employment
Uninsured
Office of Health Policy, Oregon



Office of Health Policy, Oregon

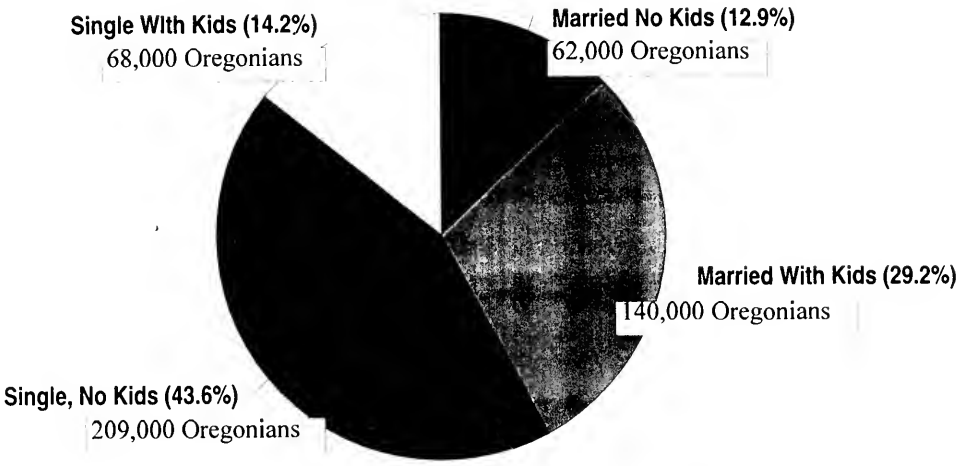

Uninsured Adults by Income
200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
Number Uninsured
1990
1992
Under $5,000
$5,000 to $14,999
$15,000 to $24,999
$25,000 to $34,999
$35,000 to $44,999
$45,000+
Income
Office of Health Policy, Oregon

Uninsured Oregonians by Percent of Federal Poverty Level in 1992



Office of Health Policy, Oregon

Family Composition of the Uninsured in 1992



Office of Health Policy, Oregon

NFIB Oregon

National Federation of
Independent Business

TESTIMONY OF E. JOE GILLIAM JR.
OREGON STATE DIRECTOR
NATIONAL FEDERATION OF INDEPENDENT BUSINESS

BEFORE THE HONORABLE RON WYDEN AND
THE HONORABLE MIKE KOPETSKI
SEPTEMBER 1, 1993

I represent over 16,000 small Oregon businesses. Over two-thirds of them employ fewer than 10 people, and gross less than $500,000 in sales. There are NFIB members in every Oregon county.

For the last five years I have been on the battle front of the Health Care Reform issue in this state. I would like to say I have been at the table, but the effort to "reform" our health care system has been nothing more than a flagrant assault on small business owners.

Under the guise of "reform", everything from higher taxes, increased reimbursements for doctors, and increased benefit levels have been advocated and to some extent achieved. The cost has been ignored because those who profit from the system and those who believe they have a right to any and all benefits have done their political homework.

So as we dance around the health care system and try to position ourselves to be the heroes who bring health care to the masses, let's stop a moment to recognize what work has to be done to solve the problem.

* We must recognize that this is not a business/labor issue. It is societal and individual issue. Each person who benefits from the system, has a responsibility to contribute to the support of the system.

* We must recognize that cost is THE problem. Not access. Not small employers.

* Small employers need to be asked to the table, not treated as targets. The present system provides coverage for 85% of the population with employers being the largest participants in paying the bill.

If we get over these obstacles and if the political players abandon back door legislative tactics to blind side their adversaries, I believe we can then begin to reach agreements on cost controls, affordabiltiy, access, quality, and a defintion of "basic" health care.

Thank you for this opportunity to address you today, I am available to you for questions.

Suite 211, 1241 State St
Salem, OR 97301
(503) 364-4450
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The Guardian of
Small Business

STATEMENT
on
HEALTH CARE REFORM
before the
HOUSE SUBCOMMITTEE ON REGULATION,
BUSINESS OPPORTUNITIES, AND TECHNOLOGY
of the
HOUSE COMMITTEE ON SMALL BUSINESS
for the
U.S. CHAMBER OF COMMERCE
by
Eugene Wigglesworth
September 1, 1993

Good morning, Mr. Chairman and members of the committee. I am Eugene Wigglesworth, testifying on behalf of the U.S. Chamber of Commerce, a membership organization of 215,000 businesses, 96 percent of which employ fewer than 100 people, as well as 3,000 local and state chambers of commerce, 1,200 trade and professional associations, and 68 American Chambers of Commerce Abroad. I own eight Midas Muffler Shops, five of which are in Oregon, including three in the Portland area. I currently employ 21 Oregonians out of some 40 to 45 workers. I also serve on the Board of Directors of the Pacific Automotive Trade Association (PATA), which offers, through a broker, health insurance to members. As a member of the Board, I have worked closely with the broker in choosing plans and negotiating premiums.

Both as a small business owner and a member of PATA's board, I am all too familiar with increasing health care costs. In addition, as an employer whose employees have young families to support, I am concerned about the effects of these escalating costs on my staff. For example, I previously insured my employees through Blue Cross/Blue Shield. Because of rising health care costs, however, I could keep premiums affordable only by increasing the deductibles. My employees, many of whom have young children and limited savings, found deductibles particularly onerous. So I did some research and found a Kaiser plan with no deductibles but with a slightly higher premium rate. After putting it to a vote among my employees, we decided

to go with Kaiser, even though that meant my employees themselves would contribute more to the premium.

My business' experience with rising health insurance costs is indicative of the need for reform of the health care system. Statistics underscore the urgency of rising health care costs. I have included a number of charts (see Attachment A) in my testimony. The first few show statistics widely discussed in recent months, including the growing part of the nation's gross domestic product consumed by health care, the projected growth in health care expenditures as a proportion of the federal budget, and the rapid escalation of employer- and employee-paid health insurance premiums. I would particularly like to highlight that this problem is not uniquely American as some would assert, but one afflicting most industrialized nations. Canada, for example, is widely cited as a model for America's health care reform. But you will note that Canada's average rate of growth in health care costs has outpaced that in the United States.

To the extent that our health insurance system is employer-based, statistics also bear out the impression that lack of insurance coverage is predominantly a small business problem. You have heard that 85 percent of the 36 million people who lack health insurance have some connection to the work force. The majority of the uninsured -- 53 percent -- are full-year, full-time workers. Others may be seasonal, part-time, or temporarily unemployed workers. Nearly two-thirds of the uninsured work for companies with fewer than 100 workers. Most are in families with incomes under 200 percent of the federal poverty limit. Thus, the profile of a typical uninsured person, if there is such a thing, is a low-paid, small business worker or family member.

The Chamber often hears that some people choose to forego insurance -- particularly when an employee premium contribution is required. In fact, research indicates that relatively few employees actually refuse coverage when it is offered: only 2 percent of workers declined health insurance from all sources. In an article published in the 1993 supplement of *Health Affairs*, a health policy journal, Steven Long and Susan Marquis found that more than 63 percent of employees in companies not offering health insurance earned less than $7 an hour. Long and

Marquis suggest that these firms may not offer health insurance because these workers are not demanding it as well as because the firm cannot afford to provide it. For a $7-an-hour worker, contributing even 20 percent of a $4,000 family premium ($800) may not be affordable, and for the small business employing that worker, contributing 80 percent of the premium would increase labor costs by 22 percent. For small business members, many of whom operate on thin margins, these increased labor costs could spell lost jobs or failed companies.

Some policymakers have suggested that these marginal companies do not deserve to be in business, as if operating a business is a privilege and not the underpinnings of our economy. Yet small businesses, by creating jobs, support tens of millions of families. We simply must accept that because of the difficult and competitive business environment in which most small businesses operate, some do not have margins that enable them to provide health insurance.

Small businesses that do provide health insurance indirectly subsidize businesses that do not provide insurance. When an uninsured worker gets medical care and cannot pay her bill, hospitals and doctors raise prices to other privately insured patients to compensate. Because big businesses have the clout to negotiate volume-discount deals with hospitals and doctors, this cost-shifting falls harder on small businesses in the form of higher premiums. Under the current health insurance system, in effect, small companies are penalized for providing coverage to their employees.

Chamber members recognize that employers have a critical role to play in reforming our health care system. We are in favor of a system that achieves affordable health insurance coverage by building on the strong current base of employer-provided health benefits. Chamber members, perhaps surprisingly, maintain that health insurance should remain part of the compensation package. However, employers have no wish to claim sole responsibility for insuring the American population. The Chamber seeks participation by all levels of society -- government, employers, and individuals -- in a framework of managed competition. No one should be permitted to opt out of the system or its obligations, but no one should be ruined in the process.

By managed competition -- a phrase used loosely in recent months -- the Chamber means roughly the model developed by Stanford Business School professor Alain Enthoven, physician Paul Ellwood, and those who form the Jackson Hole Group. This health care reform model seeks to alter the incentives in the delivery of medical services so that consumers seek high-quality care at a reasonable price and physicians, hospitals, and other health care workers compete to provide it. Under managed competition, consumers and employers armed with objective information on price and quality would shop for health coverage. Changes in the tax code would give people an incentive to choose cost-efficient plans, and small businesses and individuals would pool their purchasing power to give them greater market clout.

The Chamber has been asked whether this position implies support for an employer mandate. While we are convinced that health care costs can only be contained if everyone is in the system and playing by the same rules, we recognize that some individuals and employers are unable to afford insurance. Chamber policy holds that individuals should be required to have insurance coverage, while employers should make insurance available to workers and dependents and contribute something to its cost. However, the Chamber will oppose any health insurance requirement that does not include adequate subsidies for lower-wage workers and their employers. An insurance mandate that produces job loss and business failure is not a social gain.

The Chamber has long called for some type of group mechanism that would enable small businesses to band together for greater power in the market and economies of scale. Larger employers have always been able to have more control over health care costs, by utilizing self-insurance, managed care, and even wellness programs. Small business, on the other hand, traditionally has been limited to commercial insurance, which carries high administrative cost and permits little flexibility. In addition, self-employed businesspeople have been unable to deduct the full cost of health insurance premiums.

Purchasing cooperatives, as envisioned under managed competition, fit this bill --*provided* they remain focused on small business. In this way, small businesses and individuals will finally

have the leverage to compete against larger companies in the market for health insurance. Many of the Chamber's smaller members eagerly welcome the idea of one-stop shopping -- that they can call and get from a single source all necessary information about health care plans, prices, and quality without having to spend hours on the phone calling around to agents. The Chamber's smaller members are in the business of selling hardware or lumber or manufacturing coolers, and have neither the time nor the expertise to sift through health insurance policy language to find the appropriate features and the best deal.

It will not surprise you to hear that small business owners similarly feel unable and unwilling to devote hours on end to complying with, or trying to determine whether in fact they are complying with, intricate federal regulations. For businesses of all sizes, this is a matter of conviction as well as practicality: we do not believe that government bureaucracy can increase efficiency or lower costs in the health care system, and we *know* government red tape is not conducive to our own concentration on running a business. Thus, the Chamber will oppose cost-containment efforts that rely more on regulation than on market competition, because we, as Chamber members, believe that a market, properly structured, will be more successful in holding the line on health care costs than will government price controls.

While Chamber members naturally focus on how health care reform will affect the private sector, we are convinced that reform cannot succeed unless it applies to public programs as well. The Chamber foresees future Medicare beneficiaries choosing to remain in their existing care networks rather than transitioning to an artificially preserved fee-for-service environment. Medicaid beneficiaries could be brought into the reform mainstream immediately, obtaining coverage through a purchasing cooperative like any other individuals, but with government assistance to pay the premiums. The Chamber would caution, though, that the Medicaid population should be pooled separately for premium purposes, so that small businesses participating in the cooperative are not forced inadvertently to subsidize the relatively sicker Medicaid population.

There has been some discussion of adding still another program to the reform mix by including the medical component of workers' compensation insurance. However, the Chamber task force that is exploring this idea has some reservations. While on its surface seamless coverage sounds appealing, the Chamber has serious concerns about its impact on the workers' compensation program. The Chamber cautions that any changes to workers' compensation must preserve employers' incentives to maintain a safe workplace. The current safety incentives, including experience rating, should be retained for workers' compensation. Employers with good safety programs should continue to benefit from their efforts and should not be required to subsidize unsafe employers. Employers must retain the ability to manage disability cases for maximum and timely rehabilitation with an eye toward controlling indemnity costs. The Chamber has received letters from many small business members expressing satisfaction with their workers' compensation insurers' efforts to manage cases and control costs.

Various health care reform ideas have been discussed and debated at length over the past few years. This year, most reform efforts have been suspended in anticipation of President Clinton's reform plan. Like everyone else, the Chamber is reserving judgement until a plan is announced. The Chamber's reaction will be based largely on how small business issues are addressed. No doubt at that point the Chamber will have many things to discuss with this subcommittee. But the point I hope to leave you with is that we don't want to see real reform dissipated in endless discussions. The Chamber's small business members over the past five years have watched health care costs hockey-stick upward, squeezing wage increases and profits alike. The status quo -- 30 percent rate increases annually -- is unsustainable. We look forward to working with you over the coming months to secure real improvements in the nation's health care system.

Statement of the U.S. Chamber of Commerce

ON: HEALTH CARE REFORM

TO: HOUSE SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND TECHNOLOGY OF THE HOUSE COMMITTEE ON SMALL BUSINESS

BY: EUGENE WIGGLESWORTH

DATE: SEPTEMBER 1, 1993

The U.S. Chamber of Commerce is the world's largest federation of business companies and associations and is the principal spokesman for the American business community. It represents more than 215,000 businesses, plus 3,000 local and state chambers of commerce, 1,200 trade and professional associations, 68 American Chambers of Commerce Abroad, and 11 bilateral international business councils.

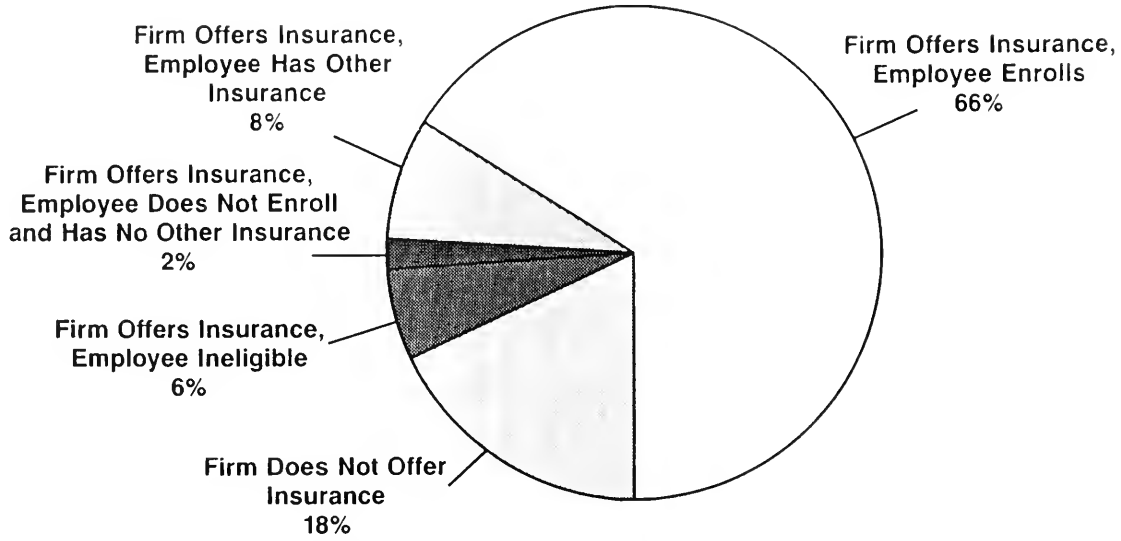
More than 96 percent of the Chamber's members are small business firms with fewer than 100 employees, 71 percent of which have fewer than 10 employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business -- manufacturing, retailing, services, construction, wholesaling, and finance -- numbers more than 11,000 members. Yet no one group constitutes as much as 36 percent of the total membership. Further, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. It believes that global interdependence provides an opportunity, not a threat. In addition to the 68 American Chambers of Commerce Abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of its members serving on committees, subcommittees, and task forces. Currently, some 1,800 business people participate in this process.

Few Decline Insurance

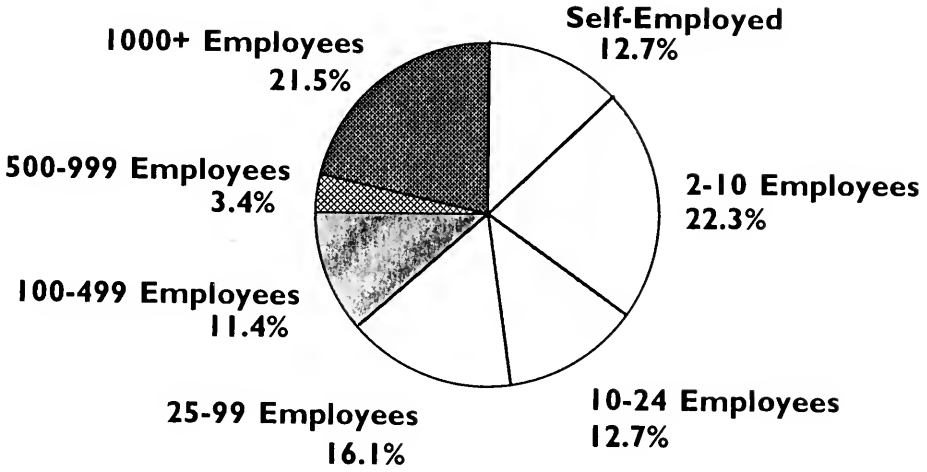


Source: Long and Marquis Tabulation of May 1988 Current Population Survey Employee Benefits Supplement (Health Affairs, Supplement 1993)

Chamber Guidelines

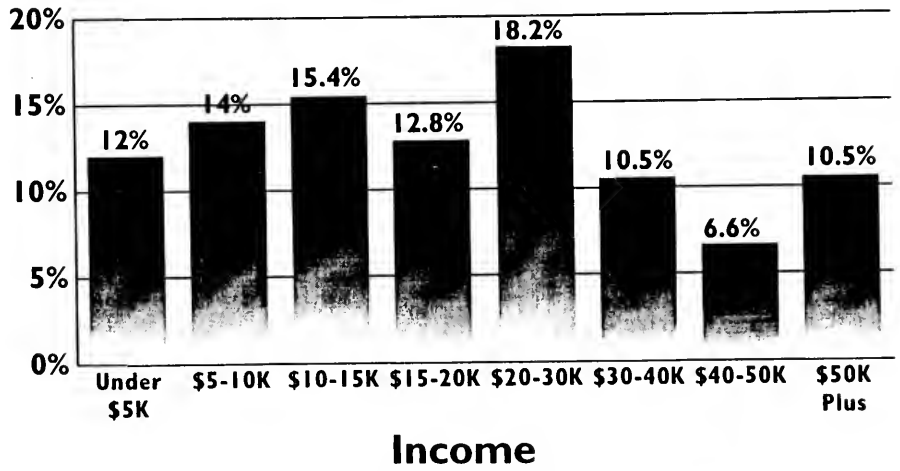
1. Managed competition strategy must be comprehensive, equitable
2. Universal coverage needed, but low-wage workers/ERs cannot pay full cost
3. Core benefits: require EE cost sharing, appropriateness reviews
4. Leave self-insured ER market intact
5. Focus HIPCs on small (under 100) ERs; flexible admin.; insurance reform
6. Maintain flexibility/innovation in delivery
7. Public programs: end cost shift; use managed care
8. Oppose price/premium regulation; open to limit on tax-free treatment to EEs

65% of Uninsured Workers are in Firms Under 100



Source: Employee Benefit Research Institute, Special Report, January 1993.

54% of Uninsured are in Families with Income Below $20,000



Source: Employee Benefit Research Institute, Special Report, January 1993.

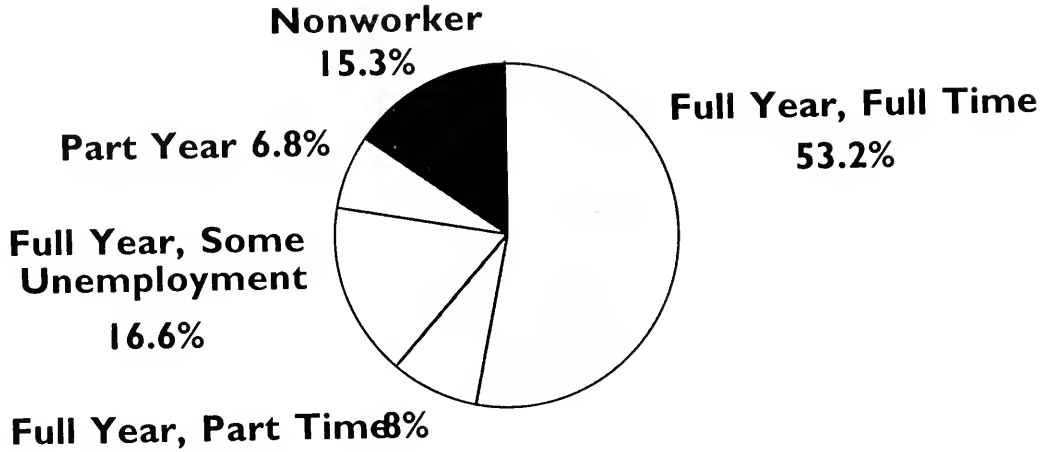
The Problem is Not Confined to the U.S.

International Growth in Per Capita Health Spending (Compounded Annual Growth Rate)

	1960-87	1960-70	1970-80	1980-87
Canada	10.7%	9.3%	12.5%	9.9%
France	13.4	12.2	15.9	10.9
Germany	9.1	9.1	12.0	5.1
Italy	16.8	13.7	21.9	14.1
Japan	14.5	20.1	15.4	5.4
United Kingdom	12.4	12.6	19.0	9.3
Average	12.8	12.8	16.1	9.1
United States	10.2	8.1	11.5	9.4

Source: Scheiber and Poullier, Health Affairs, Fall 1989

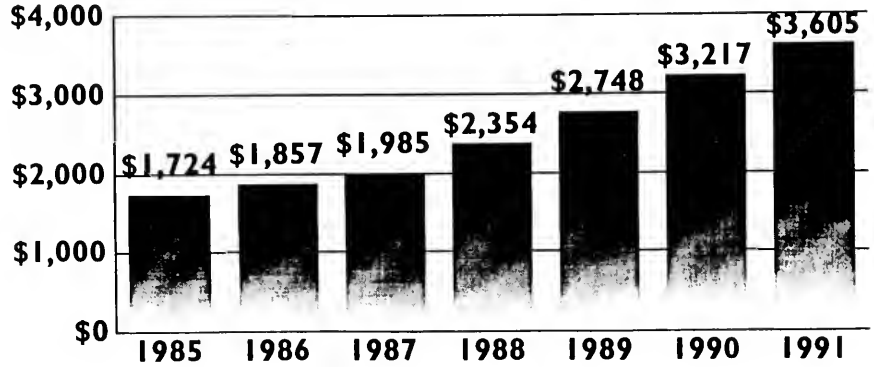
85% of Uninsured are in Families Headed by Workers



Source: Employee Benefit Research Institute, Special Report, January 1993.

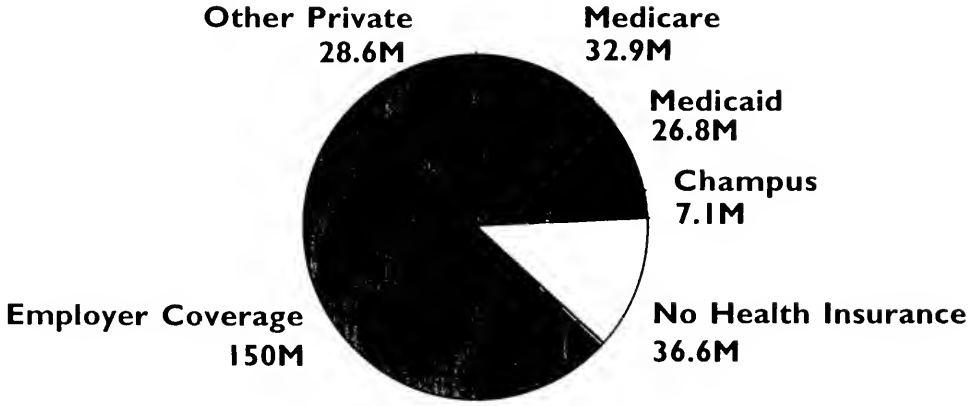
Employer - Employee Health Care Costs Have Doubled in Six Years

Growth in Total Health Plan Cost*



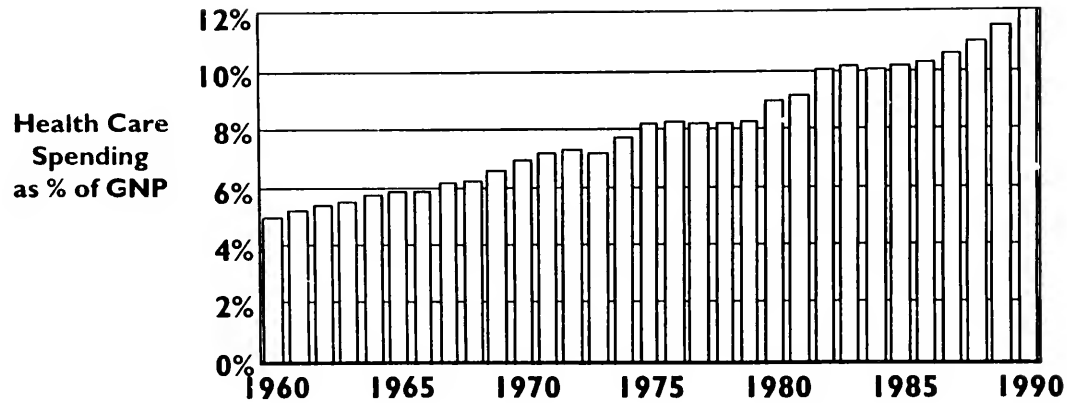
*Includes employer and employee costs for indemnity plans, HMOs, dental plans and vision/hearing plans.
Source: A. Foster Higgins & Co., Inc.

Even While Costs Grow, 36.6 Million People are Uninsured



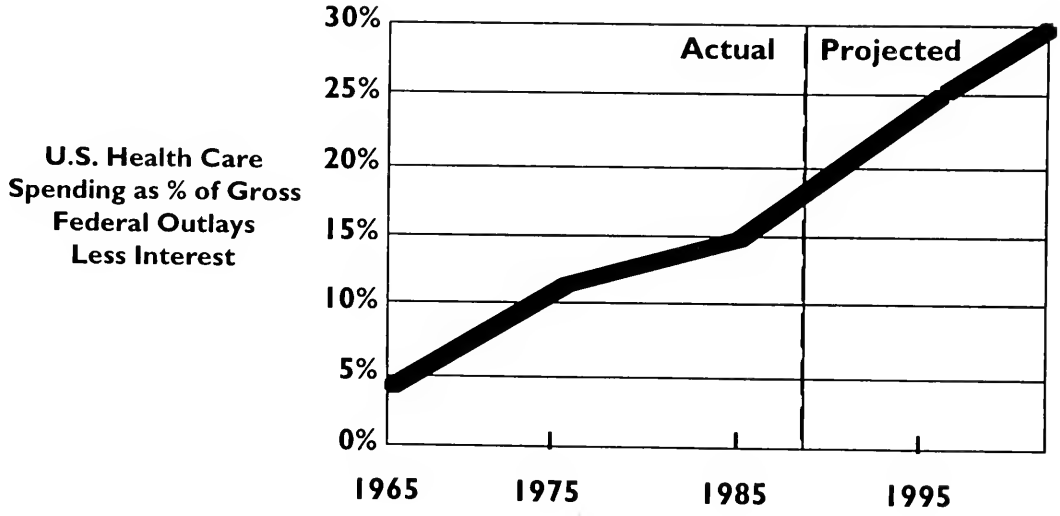
Source: Employee Benefit Research Institute, Special Report, January 1993.

Health Care Consumes a Growing Share of U.S. Resources



Source: Health Care Financing Administration, 1991

Health Care Costs are Crowding Out Other Public Programs



Source: Congressional Budget Office, 1992

Micro One

September 1, 1993

The Honorable Ron Wyden

Testimony to the House Subcommittee on
Regulation and Business Opportunity

Miriam Selby, Micro One, Inc.

I appear today as a small business owner in support of a rational, cost-effective health care system for all Americans. I am in opposition to a mandate that small businesses pay the cost of providing health care.

I am testifying today to provide you with a case study of the impact on one small business of mandating small businesses to pay for health care insurance for their employees.

I am co-owner of Micro One, Inc., a seven-year old computer consulting and programming business. We range from 7 to 12 full time employees plus we have a network of contract programmers. We provide no health care insurance. Employees either have no insurance, pay for it themselves, or are covered by their spouse's insurance.

Since the work we perform is based on the contracts that we have with businesses and government, our workload and hence billings and revenues fluctuate. When contracts are completed and new contracts are slow to materialize or are delayed in starting, our cash flow suffers. This is when we cinch in our belts, cut all unnecessary costs, and the owners sometimes forego paychecks or get reduced paychecks. When contracts proceed again, then we pay deferred bills. However, the margin is so slim in our business (and I suspect in many small businesses) that there is never a time to pay bills ahead, or save for the next valley in our workload. Generally, we are just catching up with our bills.

I have investigated providing health insurance. However, I cannot get around the fact that health care insurance is not something you can stop when times are lean. Since our business fluctuates so greatly, it would be extremely difficult to keep current with monthly health insurance bills.

Micro One, Inc.
Innovative Computer Solutions
50 S W Second, Suite 300
Portland, Oregon 97204-3538
FAX (503) 241-1424
(503) 241-0944

If health care is mandated, here are my choices:

- Let personnel go so that we can afford the costs of other employees' payroll. However, this seriously reduces our gross revenues, because our revenue is based on the billable hours that each person makes.
- Reduce salaries or delay giving raises and use the money instead for health insurance. This hurts morale and encourages staff look for another job. Our pay scale now is already quite low compared to most high tech companies in the area. High turnover of staff clearly affects the quality of work we perform and certainly our bottom line.
- Increase the hourly rate that we charge to our customers. This simply passes the health care costs along to other businesses and to government. It would also make us less competitive and impact our ability to get business.

In short, having to pay health care insurance for our employees would severely impact Micro One's ability to stay profitable and in business.

The second reason I do not support mandated health care costs for small business is that it hides the issue of cost containment. It makes us think that we've solved the problem, but ignores the escalating costs in the health care and insurance industries. There would be no incentive to reduce health care costs because "someone else would be paying." None of the needed major changes in the health care system would occur. Until realistic, effective, mandatory cost containment is part of the total package, health care for all will not be solved in this country.

What I do favor is a single payer system, an American version modeled after the Canadian system. Costs would be reduced by eliminating unnecessary levels of administration, by providing preventive care, and by better allocating medical resources. I know there are many proposals for a single payer system, and I would support the simplest, most cost-effective one. **I urge you to ignore all the vested interests** and design the best possible health care system for America.

Thank you for your time.

September 1

HOUSE SMALL BUSINESS SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES AND TECHNOLOGY

STATEMENT OF

EUGENE A. SAYLER

PRESIDENT OF SAYLER'S OLD COUNTRY KITCHEN, INC.

ON BEHALF OF THE

NATIONAL RESTAURANT ASSOCIATION

National Restaurant Association, 1200 Seventeenth Street, NW, Washington, DC 20036, 202/331-5900, FAX: 202/331-2429

Testimony before the House Small Business Committee
Subcommittee on Regulation, Business Opportunities and Technology
Statement of Eugene A. Sayler
September 1, 1993

Mr. Chairman and members of the subcommittee –

My name is Eugene Sayler. I am President of Sayler's Old Country Kitchen, Inc. We have two restaurants in the Portland area. I am the past president of the Oregon Restaurant Association and currently serve on the Board of Directors of the National Restaurant Association, representing the State of Oregon.

Foodservice operators are tremendously concerned about health care reform. For the past few years, restaurateurs have struggled with double-digit inflation in premium costs and cancellations and denials of coverage.

But as much as restaurateurs want to see the system changed, they are even more frightened by the prospect of a health benefits mandate. Mandating that employers provide health coverage, or requiring them to pay a "premium" to pay for health benefits, would sound the death knell for thousands of restaurants and the jobs they provide. This sub-committee above all others, must be sensitive to these fears.

Mr. Chairman, I would like to ask that this document be included in the record. It outlines chronologically the laws Congress has passed since 1985, that have affected employers in the restaurant industry (*see Attachment A*). There are many, and all have increased the cost of doing business. I urge you to not forget the many burdens small businesses throughout this country are grappling with – in addition to the additional costs placed on them with passage of the budget proposal.

In our efforts to provide valuable information for the health care reform debate, the National Restaurant Association has undertaken research that will give us answers to many of the questions you raised in your letter of invitation to testify. Information like, who does and does not provide insurance, what does it cost, what have recent premium increases

been, worker's compensation costs and others. Unfortunately, our data has not been fully analyzed. We will be happy to share the results, however, as soon as they are available. Our preliminary results confirm what we have been saying for years:

- Among restaurants with sales of $1 million or more, well over two-thirds offer benefits to hourly and salaried workers.

- Most small restaurants with sales under $500,000 do not offer health insurance.

- Of those restaurateurs who do not offer a health plan, almost four out of five indicated they would if insurance rates were lower.

- Almost two out of three surveyed restaurateurs said they cannot pass on the cost of employee health insurance to customers in the form of higher prices.

Other association research shows us that if Congress and the Administration require employers to pay a payroll tax of 7% for only their employees working 17½ hours per week or more to finance health care reform, an average mid-sized restaurant's pre-tax income would plummet from over $12,000 in the black to over $2,000 in the red (*see Attachment B*). This is a typical mid-sized tableservice restaurant – one with about $750,000 in sales, 12 full-time and 19 part-time employees, and an average per-person check of $9.26.

I remind you that restaurants cannot "pass along" the added cost of a health care payroll tax to customers. Restaurant customers are extremely sensitive to price increases. The higher labor costs would have to be made up instead through cutbacks on hours and jobs.

While we talk about the impact of health care reform legislation on our businesses, it is only appropriate that we consider the impact on our employees. We need to know what they want and don't want. Recently the National Restaurant Association completed a nationwide

survey of 1,000 adult restaurant workers. Three out of four surveyed employees opposed requiring employers to pay a health care payroll tax of 7 to 9%, knowing that such a tax could result in a cutback of hours and layoffs.

Why does a health care mandate spark such concern? In a word, COST. Believe me, restaurateurs would provide insurance benefits if they could afford the premiums. Many restaurants already offer health benefits. Nearly three out of five of surveyed employees said they work for a restaurant that provides a health insurance plan.

Let me give you some examples of why the foodservice industry differs from other industries in several important respects.

- **First,** *we are dominated by small businesses.* Over 70% of all eating and drinking establishments have annual sales of less than $500,000 and have an average workforce of less than 50 employees.

- **Second,** *our profit margins are slim.*

- **Third,** *we employ an extremely diverse workforce.* We employ more teens than any other industry. Fifty-nine percent of our workers are women, including 70% of foodservice supervisors. Sixty-seven percent are unmarried, and 76% live at home with their parents or relatives.

- **And fourth,** *we are labor-intensive.* Today the foodservice industry is the nation's largest retail employer. Our industry employs nine million Americans. By 2005, that number will climb to an estimated 12 million.

The combination of these characteristics means we are particularly vulnerable to labor-cost increases while at the same time lacking options for absorbing these cost increases.

You asked for advice on how we could best achieve universal health coverage. The National

Restaurant Association believes that we need to focus instead on providing **universal access to** coverage. We believe that the best way to increase access to health care is to make insurance coverage more affordable. We support market-based solutions that build on the strengths of our free-enterprise system. Here are the reforms we urge you to adopt:

- **One**, we support the establishment of health insurance purchasing pools that would help small businesses and uninsured Americans buy quality health insurance at affordable rates.

- **Two**, we support tax changes to give sole proprietors, S corporations and partnerships a full tax deduction for the cost of health insurance premiums. More than four out of ten eating and drinking places fall in these categories. We also support tax changes to limit the employer's tax deduction and employee's tax exclusion for excessive health coverage costs. Unlimited tax advantages have contributed to the growth of unnecessary medical care and wasteful spending.

- **Three**, we support reforms to the insurance market for small businesses, so employers and employees are guaranteed insurance coverage that can't be canceled on a whim.

- **Four**, we support federal pre-emption of costly state laws that require even basic benefit plans to include extensive coverage.

- **Five**, we support reducing paperwork by creating a uniform electronic claims system that guarantees timely payments and curtails fraud.

- **And finally**, we support reforms to the medical-malpractice laws so doctors won't resort to excessive tests and procedures solely to shield themselves from lawsuits.

These are real reforms that will make it possible for small businesses to provide health insurance to their employees, leading many more Americans to become covered by health

insurance.

In conclusion, I again stress that thousands of the nation's foodservice employers want to provide health care coverage but cannot afford to. A mandate from Washington today will force cutbacks in hours and jobs, cause many restaurants to close their doors and discourage more restaurants from opening.

Thank you for your attention. I would be happy to answer any questions you might have.

Attachment A

Federal Regulation and Restaurants

Just over the past eight years, restaurants have seen a tremendous increase in the number of federal regulations with which they must comply. It is no wonder that restaurants, already experiencing the cumulative impact of these laws on costs and paperwork, are extremely worried about the proposals Congress is now discussing, including a cut in the business meal deduction to 50%; higher payroll taxes to pay for health care reform; an increase in the minimum wage; and workplace-safety reforms.

Laws Congress Has Passed Since 1985
That Have Affected Employers in the Restaurant Industry

1985

■ **COBRA.** Employers of 20 or more must allow former employees and beneficiaries to continue buying into group health plans for a limited time. *(Consolidated Omnibus Budget Reconciliation Act of 1985)*

1986

■ **BUSINESS MEAL DEDUCTION.** Tax deduction for business meals cut to 80% beginning 1987. *(Tax Reform Act of 1986)*

■ **SECTION 89**. Employers must prove benefit plans do not discriminate in favor of highly-paid workers. Law repealed in 1989. *(Tax Reform Act of 1986)*

■ **IMMIGRATION**. Employers must examine documents, fill out I-9 forms for all new employees. *(Immigration Reform and Control Act of 1986)*

1987

■ **FICA TAX ON TIPS**. Restaurateurs must pay FICA taxes on all employee tips. *(Omnibus Budget Reconciliation Act of 1987)*

■ **ALCOHOL-SELLERS' TAX**. Restaurants and other businesses selling alcohol must pay $250 annual occupational tax, up from $24 or $54. *(Omnibus Budget Reconciliation Act of 1987)*

1988

■ **HAZARD COMMUNICATION STANDARD**. Due to court ruling, employers must establish an employee training program and maintain Material Safety Data Sheets for all hazardous substances in the workplace.

■ **POLYGRAPH BAN**. Bans polygraph testing, requires workplace notice explaining ban. *(Employee Polygraph Protection Act of 1988)*

■ **PLANT CLOSINGS**. Requires employers of 100 or more to give 60 days' notice of closings or mass layoffs. *(Worker Adjustment and Retraining Notification Act of 1988)*

1989

■ **MINIMUM WAGE**. Increases minimum wage to $3.80 in 1990, $4.25 in 1991. *(Fair Labor Standards Act Amendments of 1989)*

1990

■ **ADA**. Prohibits discrimination against people with disabilities. Creates significant new responsibilities in hiring and in restaurant accessibility. *(Americans with Disabilities Act of 1990)*

■ **MENU LABELING**. Beginning in 1994, requires restaurants to meet new federal criteria when they make nutrient-content or health claims. *(Nutrition Labeling and Education Act of 1990)*

■ **ALCOHOL TAXES**. Raises federal excise taxes on beer, wine, and distilled spirits in 1991 and requires payment of one-time inventory tax. *(Omnibus Budget Reconciliation Act of 1990)*

■ **TEEN LABOR PENALTIES**. Raises maximum per-employee penalties to $10,000, up from $1,000. *(Omnibus Budget Reconciliation Act of 1990)*

1991

■ **CIVIL RIGHTS**. Lets employees bring jury trials, collect money damages for job discrimination under Title VII of the Civil Rights Acts of 1964, Title I of the ADA. *(Civil Rights Act of 1991)*

1993

■ **FAMILY AND MEDICAL LEAVE**. Effective August 1993, requires employers of 50 or more to provide up to 12 weeks of unpaid, job-protected family and medical leave to employees. *(Family and Medical Leave Act of 1993)*

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1. Take a typical full-menu tableservice restaurant with annual sales of $500,000–$999,999

Profile*

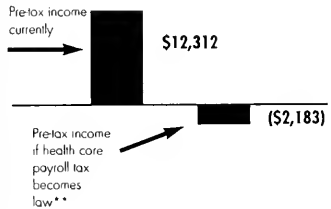
- Annual sales are $749,566
- Single-unit, independent restaurant
- Employs 12 full-time and 19 part-time employees
- Serves lunch and dinner
- Has over 150 seats
- Operates as a private corporation
- Average per-person check is $9.26
- Pre-tax income is 1.6% of sales

Income and expense statement*

INCOME	
Total sales	$749,566
Total cost of sales	$264,635
Other income	$ 37,507
TOTAL INCOME	**$522,438**
EXPENSES	
Controllables	
• Payroll and benefits	$268,859
• Direct operating expenses	$ 58,992
• Marketing, music/entertainment	$ 21,251
• Utilities	$ 23,875
• Administrative/general	$ 29,154
• Repairs/maintenance	$ 15,175
Total Controllables	$417,306
Occupancy costs	
• Rent	$ 34,790
• Property and other taxes	$ 10,101
• Property insurance	$ 7,411
Total Occupancy Costs	$ 52,302
Total other (interest, depreciation, corporate overhead, other deductions)	$ 40,518
TOTAL EXPENSES	**$510,126**
PRE-TAX INCOME	**$ 12,312**

*Information on typical restaurant represents averages for full-menu tableservice restaurants with annual sales of $500,000–$999,999 that responded to the Restaurant Industry Operations Survey 1992, National Restaurant Association, Deloitte & Touche

2. If Congress and the President required employers to pay a 7% payroll tax to fund health care, what would happen to that restaurant?



Income before income taxes — Current $12,312
(1.6% of the restaurant's $749,566 in sales)

Estimated cost of a 7% health care payroll tax $14,495

Income before income taxes — If health care payroll tax becomes law ..... ($2,183)**

** This shows the direct impact of the proposal, not taking into account any measures the restaurateur might take to minimize losses

Methodology

The above data measures the impact on this restaurant of assessing a 7% payroll tax on employers for all employees working 17.5 hours per week or more. This example assumes that this restaurant does not provide health benefits. Such a payroll tax has been suggested previously as part of a health care reform plan that would require employers to either provide health benefits or pay the payroll tax.

This establishment employs 12 full-time workers at 35 hours per week, 12 part-time employees working 20-34 hours per week and 7 part-time employees working less than 20 hours. Analysis assumes employees working less than 20 hours actually work less than 17.5 hours and excludes them from calculations. Average hours worked among those employed 20-34 hours is assumed to be 26 hours. Payroll for employees working 20 or more hours per week is estimated using average payroll per full-time equivalent employee of $9,901, derived from payroll and benefits data for full-menu tableservice restaurants with sales between $500,000 and $999,999. Payroll for full-time employees = $9,901 x 12 = $118,812. Payroll for part-time employees = $9,901 divided by 35 = $282.89 x 26 = $7,355 x 12 = $88,260. Payroll for employees working 20+ hours = $207,072. A 7% payroll tax = $14,495.